



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 28, 2026

Licensee

Empathy Home Care Inc
7333 Kentucky Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL34730016

Dear Licensee:

On April 8, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 7, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 7, 2026 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 7, 2026, found not corrected at the time of the April 8, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - \$500.00
0510-Infection Control Program-144g.41 Subd. 3 - \$500.00
0650-Staff Records-144g.42 Subd. 8 (a) - \$500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - \$500.00
1730-Individualized Medication Management Plan-144g.71 Subd. 5 - \$500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - \$500.00
1890-Prescription Drugs-144g.71 Subd. 20 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 8, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/08/2026
NAME OF PROVIDER OR SUPPLIER EMPATHY HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7333 KENTUCKY AVENUE NORTH BROOKLYN PARK, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL34730016-1 On April 7, 2026, through April 8, 2026, the Minnesota Department of Health conducted a follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on January 7, 2026. At the time of the survey, there were eight residents, all of whom received services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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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 observation, interview, and record review, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 470}			

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{0 470}	Continued From page 2 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: The licensee's facility was a duplex with two separate addresses. The last two numbers of the addresses were 25 and 33. The licensee was licensed as a campus. The licensee's plan of correction dated 2026 indicated the licensee made a process for the delivery of schedules to the facility. On April 7, 2026, at 9:20 a.m., the surveyor observed a daily work schedule posted on the bulletin board near the kitchen on the 25 side of the duplex. The daily work schedule was dated Monday March 23 through Sunday March 29. The schedule included multiple facilities managed by the parent company, the ULP who were assigned to work at the facility, and their hours for the day. The surveyor did not observe a daily work schedule posted in a central location on the 25 side of the duplex for April 7, 2026. On April 8, 2026, at 10:12 p.m., owner/clinical nurse supervisor (O/CNS)-C stated the licensee had consistent staff members and they created a daily work schedule to be posted that was two weeks in length. O/CNS-C stated a few days prior to a new schedule needing to be placed, they would create a new schedule at the office and provide the schedule to a dedicated staff member to deliver it to the facility. O/CNS-C stated they created a new schedule to be posted at the licensee's facility for April 7, 2026. O/CNS-C then	{0 470}			

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{0 470}	Continued From page 3 contacted unlicensed personnel (ULP)-B and asked them to take a picture of the schedule currently posted at the facility. On April 8, 2026, at 11:08 a.m., O/CNS-C stated ULP-B located the staff schedule and it was located in a box at the facility. O/CNS-C stated the daily work schedule was not posted at the facility. The licensee's 4.06 Staffing & Scheduling policy dated August 2, 2021, indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided.	{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	{0 480}			

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{0 480}	Continued From page 4 supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	{0 480}			

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{0 480}	Continued From page 5	{0 480}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to hand hygiene for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	{0 510}			

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{0 510}	Continued From page 6 situation has occurred only occasionally). The findings include: The licensee's plan of correction dated 2026 indicated by February 5, 2026, the licensee retrained staff on hand washing and the training was documented. On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-B wash their hands, apply gloves, gather medications for multiple residents from the medication file cabinet, and pull a small table towards the couch to set medications and computer on. ULP-B sat down on the couch and prepared and administered R7's medications. Without glove removal or performing hand hygiene ULP-B documented R7's medication administration on the electronic medication administration record (EMAR) and then prepared and administered R2's medications. Without glove removal or performing hand hygiene, ULP-B documented R2's medication administration in the EMAR and then prepared and administered R3's medications. ULP-B documented medication administration in the EMAR for R3, placed medication back into the medication file cabinet, and removed their gloves. Without performing hand hygiene, ULP-B moved the table back to its original location and then went to the kitchen table to document on resident's cares. At 8:26 a.m., the surveyor inquired why they had not performed hand hygiene after removing their gloves. ULP-B stated they forgot. ULP-B stated they were trained to sanitize or wash their hands after removing gloves. ULP-B stated they were trained in medication administration through EduCare (a training software), in person by the nurse, and by shadowing at the facility. ULP-B stated they were	{0 510}			

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{0 510}	Continued From page 7 trained to wash their hands in between residents when passing medications. ULP-B stated residents received their morning medications when they woke up and due to residents waking up at different times, they normally did not pass medications to residents one after the other. The surveyor inquired why they did not remove gloves or perform hand hygiene between the residents. ULP-B stated, "I could not take it off and do it. They all wanted it (medications)." On April 8, 2026, at 10:21 a.m., owner/clinical nurse supervisor (O/CNS)-C stated after the previous survey, staff were trained to perform hand hygiene in between resident's medication passes. The surveyor asked to see documentation of the training they provided. The surveyor did not receive documentation of the education O/CNS-C stated they provided to the employees. The CDC's document titled Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, indicated hand washing should be performed immediately before touching a patient and after touching a patient or patient's surroundings. The licensee's 8.01 Infection Control Policy dated August 1, 2021, indicated the licensee's infection control program would be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. No further information was provided.	{0 510}			
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records	{0 650}			

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{0 650}	Continued From page 8 (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 information: (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 observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of four employees (unlicensed personnel (ULP)-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	{0 650}			

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{0 650}	Continued From page 9 situation has occurred only occasionally). The findings include: ULP-K was hired by the licensee's parent company on July 15, 2025, and began working for the licensee to provide assisted living services on January 27, 2026. On April 7, 2026, at 9:37 a.m., the surveyor observed ULP-K was the only staff member working on one side of the licensee's side-by-side duplex facility. ULP-K's employee record included a Skills Competency completed July 9, 2025. The document included two columns. One column indicated training completed and the second column indicated demonstration of competency. The column for training was filled in, indicating training had been completed for every topic listed on the document. The column for demonstration of competency was left blank for every topic listed on the document. ULP-K's employee record lacked evidence of the following required competency evaluations: - appropriate and safe techniques in personal hygiene and grooming which included hair care, bathing, care and use of hearing aids, dressing, toileting, and care of teeth gums, and oral prosthetic devices; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfers techniques and ambulation; and - range of motion and positioning. On April 7, 2026, at 1:29 p.m., owner/clinical nurse supervisor (O/CNS)-C stated ULP-K	{0 650}			

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{0 650}	Continued From page 10 completed the competency evaluations listed above, and it was their error that the competency evaluation column was not documented on. On April 7, 2026, at 2:02 p.m., ULP-K stated the nurse watched them complete a return demonstration on the topics listed above. The licensee's 4.05 Employee Records policy dated January 1, 2022, indicated employee records would include records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided.	{0 650}			
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}			

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{0 660}	Continued From page 11 Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of four employees (unlicensed personnel (ULP)-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's plan of correction dated 2026 indicated by February 2, 2026, the licensee had employees recomplete a TB test or provide them with TB test results for all employees with missing personnel files. In addition, any TB tests that were completed more than 90 days before date of hire were redone. ULP-K was hired by the licensee's parent company on July 15, 2025, and began working for the licensee to provide assisted living services on January 27, 2026. ULP-K's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated July 7, 2025. The TB Blood Test and Tuberculin Skin Testing (TST) sections were not filled in with information related to ULP-K. In	{0 660}			

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{0 660}	Continued From page 12 addition, ULP-K record included a QuantiFERON TB gold test collected on July 9, 2024, which indicated ULP-K was negative for TB. ULP- K employee record lacked a valid TB screening completed within 90 days of hire. On April 8, 2026, at 11:00 a.m., owner/clinical nurse supervisor (O/CNS)-C stated after the previous survey they reviewed all employee records to ensure they had a health history screening and TB result. O/CNS-C stated they also conducted a new TB facility risk assessment. O/CNS-C stated they could use a Mantoux result that was completed one month prior to hire. O/CNS-C stated they believed they could use a TB blood test completed within five years of hire and a chest Xray if it was completed one year prior to hire. The surveyor explained when TB test could be utilized if completed prior to hire. O/CNS-C stated they did not know that. The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; - a TB test which could include TB blood test or TB skin test; and - additional evaluation for TB disease as needed. The Minnesota Department of Health (MDH) Resources and Frequently Asked Questions (FAQs) dated March 9, 2026, indicated TST or interferon-gamma release assays (IGRAs) could be accepted as an acceptable TB screen if it was dated within 90 days of being hired.	{0 660}			

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{0 660}	Continued From page 13 The licensee's 8.16 Tuberculosis Screening policy dated January 1, 2023, indicated new staff would have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No further information was provided.	{0 660}	Not reviewed during this survey.		
{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:	{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 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	{0 780}			

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{0 800}	Continued From page 15 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.		
{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 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	{0 810}			

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{01730}	Continued From page 17 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for one of five residents (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 an isolated scope (when one or a limited number of residents are affected or one or	{01730}			

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{01730}	Continued From page 18 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's plan of correction dated 2026 read, "Get clarified order for Tylenol for R3 - one one (sic) tab vs two tabs should be administered. Separate into two separate PRN entries and clarify when to do one versus the other". The document indicated the correction was completed on February 5, 2026. R3 was admitted to the licensee on September 1, 2024, and began receiving assisted living services. R3's diagnoses included schizophrenia (a mental health disorder that affects how a person thinks, feels, and behaves, often leading to a distorted perception of reality), alcohol use disorder, and major depression. R3's Service Plan (Waiver) - Addendum to Contract signed March 2, 2026, indicated R3 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, safety check shopping, socialization, monitoring of blood pressure and weight, and transportation. On April 8, 2026, at approximately 8:00 a.m., the surveyor observed ULP-B administer oral medications to R3. R3's Med Admin Summary - Month dated April 2026 included acetaminophen 500 mg take one to two tabs by mouth every six hours as needed for mild pain. The medication administration	{01730}			

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{01730}	Continued From page 19 record (MAR) did not indicate when one tablet vs two tablets of acetaminophen should be administered. R3's ongoing 90-day assessment dated March 9, 2026, indicated the following: - staff would administer all of R3's medications; - R3 needed full medication management and set up; - licensed nurse was responsible for monitoring medication supplies and reordering; - all medications were securely locked in the medication cabinets where only staff have access; - ULP were delegated to provide oral medication to R3; - ULP to call nurse if questions or concerns arise with medication management. The phone number was posted and provided in the medication plan; and - self administration was not applicable to R3 however R3 was able to do the following: - verbalize instructions on container; - verbalize what each medication was for and what the side effects where; - could state when medications were taken and proper dosage for each; - could open medication containers; - could demonstrate secure storage in room; and - could state situations for administering medications PRN. R3's medication assessment did not contain information specifically related to R3's acetaminophen. On April 8, 2026, at 10:34 a.m., the surveyor inquired why there were no specific instructions for ULP on how to administer acetaminophen. Owner/clinical nurse supervisor (O/CNS)-C stated	{01730}			

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{01730}	Continued From page 20 R3 was able to tell staff how many tablets of acetaminophen they wanted. O/CNS-C stated R3 was assessed and determined to be safe for self-administration of acetaminophen however, staff provided R3 their medication. The surveyor asked O/CNS-C where acetaminophen self-administration was addressed in the individual medication management plan. O/CNS-C was unable to provide the surveyor with documentation related to acetaminophen. R3's individual medication management plan comprised of multiple documents lacked documentation related to specific resident instructions regarding the administration of acetaminophen. The licensee's undated 7.03 Medication Management Individualized Plan policy indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident assessment that must contain a statement describing the medication management services that would be provided and documentation of specific resident instructions relating to the administration of medications. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated January 6, 2026, indicated when administration of medications was delegated to the ULP, the licensee would ensure that the registered nurse has specified, in writing, specific instructions for each resident and documented those instructions in the resident records. No further information was provided.	{01730}			

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{01760}	Continued From page 21	{01760}			
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document each medication administered by the assisted living facility staff or failed to document on why the medication administration was not completed as prescribed for four of five residents (R1, R2, R6, R7). 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: The licensee's plan of correction dated 2026	{01760}			

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{01760}	Continued From page 22 indicated by February 2, 2026, the licensee conducted a medication refresher training with unlicensed personnel (ULP). In addition, "staff must document an HPN [a progress note] for ANY unsigned spots on the med sheet." R1 R1 was admitted to the licensee on February 9, 2022, and began receiving assisted living services. R1's diagnoses included Schizoaffective disorder (mental health disorder that combines symptoms of schizophrenia and mood disorders), substance use disorder, and bipolar (mental health condition characterized by significant mood swings, including manic episode and depressive episodes). R1's Service Plan (Waiver) - Addendum to Contract signed March 5, 2026, indicated R1 received assistance with activities, appointments, housekeeping, laundry, behavior management, meals, medication administration, blood pressure monitoring, safety checks, shopping, socialization, and transportation. R1's Med Admin Summary - Actual - Month dated March 2026, lacked any documentation for the following medications/dates: - amphetamine/dextroamphetamine 30 milligrams (mg) at 8:00 a.m., on March 2, 11, 21, 22, and 23, 2026; and - metoprolol succinate 25 mg extended release (ER) at bedtime on March 12, 16, and 23, 2026. R2 R2 was admitted to the licensee on November 5, 2024, and began receiving assisted living services.	{01760}			

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{01760}	Continued From page 23 R2's diagnoses included schizoaffective disorder, anxiety, epilepsy, major depression, post-traumatic stress disorder (PTSD), and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). R2's Service Plan (Waiver) - Addendum to Contract signed March 2, 2026, indicated R2 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, safety check shopping, socialization, blood pressure and weight monitoring, and transportation. R2's Med Admin Summary - Actual - Month dated March 2026, lacked any documentation for the following medications/dates: - buspirone 20 mg in the morning on March 10, 2026; - fluoxetine 80 mg in the morning on March 10, 2026; - levetiracetam 1000 mg in the morning on March 10, 2026; and - Tab-a-Vite one tab in the morning on March 10, 2026. R6 R6 was admitted to the licensee on December 16, 2024, and began receiving assisted living services. R6's diagnoses included bipolar, depression, methamphetamine use, PTSD, and schizophrenia. R6's Service Plan (Waiver) - Addendum to	{01760}			

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{01760}	Continued From page 24 Contract signed March 2, 2026, indicated R6 received assistance with activities, appointments, housekeeping, laundry, behavior management, meals, medication administration, blood pressure and weight monitoring, safety checks, shopping, socialization, and transportation. R6's Med Admin Summary - Actual - Month dated March 2026, lacked any documentation for the following medications/dates: - azithromycin 250 mg tablet take 2 tablets by mouth today and then take one tablet daily for four more days. There was no documentation on March 4, 5, 6, 2026; and - gabapentin 800 mg at 8:30 p.m. on March 23, 2026. R7 R7 was admitted to the licensee on March 22, 2021, and began receiving assisted living services. R7's diagnoses included schizophrenia, antisocial personality disorder, cannabis use, and stimulant use disorder. R7's Service Plan (Waiver) -Addendum to Contract signed March 2, 2026, indicated R7 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, safety check, shopping, socialization, blood pressure and weight monitoring, and transportation. R7's Med Admin Summary - Actual - Month dated March 2026, lacked any documentation for the following medications/dates: - haloperidol decanoate 300 mg injections administer every 28 days lacked documentation	{01760}			

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{01760}	Continued From page 25 on March 4, 2026. R7's Med Admin Summary - Actual - Month dated April 2026, lacked any documentation for the following medications/dates: - haloperidol decanoate 300 mg injections administer every 28 days lacked documentation on April 1, 2026. On April 8, 2026, at 10:34 a.m., owner/clinical nurse supervisor (O/CNS)-C stated Residex (a documentation software) did not allow ULP to document on the electronic medication administration record (EMAR) if the medication was provided outside of the medication administration time. O/CNS-C stated staff were trained to contact a nurse if they were not able to document on a medication so the nurse could override the system to allow the ULP to document on the medication. O/CNS-C stated they worked with residents with mental health issues and residents may refuse to take their medication at the times prescribed however would eventually take their medication. O/CNS-C stated ULP attempt to take amphetamine/dextroamphetamine to R1 however, R1 would ask ULP to leave it with them. ULP knew they could not leave medication with the R1. ULP then would bring the medication back to the medication file cabinet and wait until R1 was willing to take the medication. O/CNS-C stated they believed the medication administration record (MAR) lacked documentation on the medication because it was administered after the medication administration time. O/CNS-C stated R1 has refused to take metoprolol and they have notified the prescriber however, the prescriber still wanted the medication offered to R1. O/CNS-C stated they believed R2's EMAR lacked documentation on	{01760}			

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{01760}	Continued From page 26 the medication listed above was because they were in jail on that day. O/CNS-C stated they had instructed ULP to document on the MAR for any leave of absence (LOA) when a resident is not in the facility. O/CNS-C stated R6's antibiotic listed above did not arrive from pharmacy and that was why it was not documented on in the MAR. O/CNS-C stated once the medication arrived, they received one dose and then it was discontinued when they went to the hospital. O/CNS-C stated R7's injection was administered by registered nurse (RN)-A, and they did not know why it was not documented on. O/CNS-C stated they would ask RN-A if R7 received the injection and let the surveyor know. O/CNS-C did not provide an explanation of why R7's medication was not documented prior to the completion of the survey. The licensee's 7.22 Medication & Treatment Record - Documentation and Refusal policy dated February 3, 2026, indicated if medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided.	{01760}			
{01890} SS=E	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.	{01890}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/08/2026
NAME OF PROVIDER OR SUPPLIER EMPATHY HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7333 KENTUCKY AVENUE NORTH BROOKLYN PARK, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01890}	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of eight residents (R5). In addition, the licensee failed to label prescription medications for one of eight residents (R4) and failed to date time sensitive medications once opened for one of eight residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's plan of correction dated 2026 indicated by February 5, 2026, all expired medications were removed from the facility and destroyed. In addition, the licensee completed retraining on labeling opened topicals and eye drops on the date the medications were opened. The licensee's facility was a duplex with two separate addresses. The last two numbers of the addresses were 25 and 33. The licensee was licensed as a campus. On April 7, 2026, at 9:49 a.m., the surveyor observed the licensee's medication file cabinet on the 25 side of the facility and observed the following: - R4's timolol maleate 0.5 percent (%) opened	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 28 without a date open label; and - a bottle of prednisolone acetate 1 % without a prescription label or a name of resident in R4's medication compartment in the file cabinet. On April 7, 2026, at 9:59 a.m., the surveyor observed the licensee's medication file cabinet on the 33 side of the facility and observed the following: - neomycin and polymyxin B sulfates and dexamethasone ophthalmic 0.1 % for R5 with an expiration date of October 10, 2025. On April 8, 2026, at 10:53 a.m., owner/clinical nurse supervisor (O/CNS)-C stated the nurses audited the medication file cabinets monthly. O/CNS-C stated RN-A was going to complete an audit for April on April 8, 2026. O/CNS-C stated they retrained staff on labeling eye drops once they opened them. O/CNS-C stated if they found an eye drop without a date opened label, they would contact the nurse so the nurse could verify when it was delivered and then they would place the day of delivery on the opened eye drop bottle. The surveyor requested to see the retraining provided to ULP on eye drop labeling. O/CNS-C stated two nurses, including themselves, audited the medication file cabinets after the previous survey to remove expired medications. O/CNS-C stated they both missed the expired medication listed above. O/CNS-C stated medications should have a prescription label on them and they did not know why R4's eye drop did not have a prescription label. The surveyor did not receive documentation of education provided to ULP prior to the completion of the survey. The manufacturer's instructions for timolol maleate ophthalmic solution dated 2009 indicated once timolol maleate was opened it should be	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 29 discarded after one month. The licensee's 7.08 Medication Management - Administration & Setup policy dated January 1, 2023, indicated the licensed nurse who set up the medications would also be observant of any problems regarding storage of medications. The licensee's 7.23 Medication Disposal policy dated February 3, 2026, indicated the facility shall dispose medication remaining within the facility that were expired according to the state and federal regulation for disposition of medications and controlled substances. No further information was provided.	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 28, 2026

Licensee

Empathy Home Care Inc

7333 Kentucky Avenue North

Brooklyn Park, MN 55428

RE: Project Number(s) SL34730016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 7, 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.

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 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$500.00

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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 \$2,500.00**. 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. 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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" being more prominent than the last name "DeVries".

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/07/2026
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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: SL34730016-0 On January 5, 2026, through January 7, 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 eight residents all of 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.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide		0 330		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful information to the Minnesota Department of Health (MDH) during a survey when they re-created an employee record during the survey and when owner/clinical nurse supervisor (O/CNS)-C directed another staff member to forge their signature on the documentation. 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 January 5, 2026, at 10:52 a.m., licensed assisted living director (LALD)-D stated O/CNS-C was overseas for a family emergency and O/CNS-C was having difficulty with their cellular service so was not immediately available.	0 330			

Minnesota Department of Health

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0 330	Continued From page 2 On January 5, 2026, at 1:45 p.m., the surveyor requested the personnel files for registered nurse (RN)-A and unlicensed personnel (ULP)-B. LALD-D stated they would need to go to the licensee's office (separate address than the facility) to retrieve the files. On January 6, 2026, at 10:17 a.m., LALD-D provided the surveyor with a file for RN-A and ULP-B and stated the licensee's office had been raided by the police department seven months ago and the police department took personnel files for all ULP but left the nurse's personnel files. LALD-D stated the police department had not returned the personnel files to the licensee, so they re-created ULP-B's personnel file the evening before on January 5, 2026 (the day the survey was initiated), and it would be missing the tuberculosis (TB) test because ULP-B needed to retrieve a copy to be placed into their file. LALD-D stated ULP-B's competency evaluations were backdated the evening prior to the dates they believed they were originally completed. LALD-D stated if they were unable to corroborate a date for a training, they did not create a new document, and it would just be missing from the employee record. On January 6, 2026, at 10:38 a.m., LALD-D stated on January 5, 2026, they spent three hours on the phone with O/CNS-C going through O/CNS-C's notes to create the documents for ULP-B's employee record to give to the surveyor. LALD-D stated O/CNS-C had been working on recreating the employee records that were taken by the police "but some of them [personnel files] were made last night." LALD-D stated they compared O/CNS-C's notes and talked with ULP-B to see if the trainings were completed prior	0 330			

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0 330	Continued From page 3 to filling out the forms. LALD-D stated ULP-B was able to state if they received a training however, ULP-B did not remember the dates of when trainings or competencies occurred. On January 6, 2026, at 11:06 a.m., during an interview via phone with O/CNS-C and in person with LALD-D and RN-A, the surveyor inquired why competencies and trainings were not re-done rather than back-dating documents after the personnel records were taken by the police. O/CNS-C stated they referred to sign-in records from previously held in-person trainings, RTasks transcript (a documenting software company), and an EduCare transcript (training software program). The surveyor requested that O/CNS-C provide evidence to corroborate the specific trainings, competency evaluations, and dates of when the staff member was trained that were utilized to re-create ULP-B's record. O/CNS-C provided an EduCare transcript for ULP-B that showed training completion dates for six of the 22 required training areas and evaluation topics for all ULP (who are not certified nursing assistants). In addition to those six areas, the transcript also included record of dementia training for 1.75 of the required 8 hours and one of the nine required orientation topics (Assisted Living Bill of Rights) with completion dates ranging from March 27, 2025, to April 27, 2025. The record showed no evidence of training on any other delegated tasks or of demonstration of competency evaluation. When the surveyor was attempting to discern when certain documents were re-created and back-dated, O/CNS-C stated when they realized their records would not be returned to them timely, they re-did some of the pass/fail training tests and those documents were not backdated they were only missing completion signatures	0 330			

Minnesota Department of Health

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0 330	Continued From page 4 (documents dated August 13, 2025). O/CNS-C stated they just had not signed them off as completed. When O/CNS-C stated that, the surveyor observed a confused expression come over LALD-D's face. LALD-D spoke up and contradicted what O/CNS-C stated. O/CNS-C then reasserted they re-did documentation of trainings based on the records they had available. The phone then abruptly disconnected. O/CNS-C called back; however, they continued to reiterate how they believed they obtained dates to back-date documents. O/CNS-C stated they had approximately five more employee records they planned to re-create. The call with O/CNS-C ended. LALD-D and RN-A remained in the interview with the surveyor. At 11:34 a.m., RN-A stated they signed some paperwork for ULP-B's record the day prior. LALD-D then stated O/CNS-C requested they sign O/CNS-C's signature on ULP-B's back-dated documents. LALD-D explained they were uncomfortable with the request and refused to forge a signature but instead decided to print CNS-C's name as the trainer. The surveyor asked LALD-D to pull out the documents that they created the night prior. LALD-D provided the paperwork to the surveyor separated into two different parts. The first part was documents that were 100 percent recreated on January 5, 2025; the second part were EduCare pass/fail questionnaires. LALD-D stated the EduCare pass/fail questionnaires were previously recreated by O/CNS-C however, lacked signatures. The surveyor inquired if they were to ask for another ULP's record would they find it to be empty. LALD-D stated half of the ULP folders would not have information in them however, "I will tell you; I won't back date it again" and you will just get a blank ULP folder. The following documents were confirmed by	0 330			

Minnesota Department of Health

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0 330	Continued From page 5 LALD-D as being created or signed on January 5, 2026, from either RN-A or LALD-D: - fully recreated documents: - Baseline TB Screening Tool for Health Care Workers (HCWs) - Skills Competency - Competency 14.0b: Medication Administration - Staff Orientation and Training Packet - Home Health Aide competency Test Questions - documents signed by ULP-B with printed name by LALD-D for O/CNS-C: - Bloodborne Pathogens Post Test - Clean and Safe Environment Post Test - Overview of Assisted Living Statues - Post Test - Emergency and Disaster Response Training - Post Test - HIPAA Training Post Test - Vulnerable Adult Post Test - Complaints Post Test - Home Care Bill of Rights Post Test - Covid-19 Procedures: Education and Teaching of PPE and Active Screening - Person In-Charge (PIC) Food Handler Test On January 6, 2026, at 11:41 a.m., ULP-B stated they were asked to sign all the above documents on January 5, 2026. ULP-B stated they had previously received all the training listed above however; was unsure of the dates the trainings were provided. On January 7, 2026, at 10:35 a.m., LALD-D stated ULP-B's record was the only personnel record they created or altered during the survey. On January 7, 2026, at 12:30 p.m., RN-A stated	0 330			

Minnesota Department of Health

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0 330	Continued From page 6 the only other document besides ULP-B's record they altered or created during the survey was their own baseline TB health screening tool. According to Ostendorf, P.A.P.A.G.P.P.A.S.A.H.W. R. (2025). Fundamentals of Nursing (12th ed.). Elsevier Health Sciences (US). https://bookshelf.vitalsource.com/books/9780443245336 Section 26. Informatics and documentation, page 392, Table 26.1, Legal Guidelines for Documentation indicated, "Chart only for yourself. You are accountable for information that you enter into a chart. Never chart for someone else. Exception: If caregiver has left unit for day and calls with information that needs to be documented, include the name of the source of information in the entry and that the information was provided via telephone." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of	0 340			

Minnesota Department of Health

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0 340	Continued From page 7 each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient documentation taken to comply with the correction orders from a survey completed January 18, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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 May 17, 2024, the licensee received results from the previous survey concluded on January	0 340			

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0 340	Continued From page 8 18, 2024. The longest time period for correction (the time frame by which the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was June 7, 2024. The licensee's correction orders included tag identifier 0480 related to 1446.41 Subdivision 1. Subd. 1a. (a-b) Minimum requirements; required food services., 0510 related to 144G.41 Subd. 3. Infection control program., 0650 related to 144G.42 Subd. 8. (a) Staff records., 0680 related to 144G.42 Subd. 10. Disaster planning and emergency preparedness plan., 0810 related to 144G.45 Subd. 2 (b-f) Fire protection and physical environment., 0970 related to 144.50 Subd. 5. Waivers of liability prohibited., 1290 related to 1446.60 Subdivision 1. Background studies required., 1760 related to 144G.71 Subd. 8. Documentation of administration of medications., and 1890 related to 144G.71 Subd. 20. Prescription drugs. The licensee's undated Plan of Corrections did not include information for tag identifier numbers 0480, 0510, 0650, 0680, 0810, 0970, 1290, 1760, and 1890. On January 7, 2026, at 10:30 a.m., licensed assisted living director (LALD)-D stated they had not been employed with the licensee for a long period of time and were not provided access to all of the licensee's records. LALD-D stated owner/registered nurse (O/CNS)-C was not available for interview as they were currently traveling back to the United States from a different country and their plane was located over an ocean. On January 7, 2026, at 11:22 a.m., LALD-D stated they believed O/CNS-C started to create a plan of correction but did not finish it. The	0 340			

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0 340	Continued From page 9 surveyor observed one correction order listed on the plan of correction document. During the survey initiated on January 5, 2026, and exited on January 7, 2026, areas of deficient practice related to tags 0480, 0510, 0650, 0680, 0810, 0970, 1290, 1760, and 1890 were identified and the correction orders were re-issued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient housing and service-related management, control, and operation of the facility. This had the potential to affect all 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	0 420			

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0 420	Continued From page 10 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: The licensee held an assisted living licensure issued on June 1, 2025, with an expiration date of May 31, 2026. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page five and of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by owner/clinical nurse supervisor (O/CNS)-C on February 25, 2025.	0 420			

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0 420	Continued From page 11 As a result of this survey, the following orders were issued under tag identification numbers 0330, 0340, 0420, 0470, 0480, 0510, 0550, 0570, 0630, 0650, 0660, 0680, 0775, 0780, 0790, 0800, 0810, 0830, 0910, 0970, 1290, 1500, 1530, 1565, 1620, 1730, 1760, and 1890 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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;	0 470			

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0 470	Continued From page 12 (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 observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. In addition, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's facility was a duplex with two separate addresses. The last two numbers of the addresses were 25 and 33. The licensee was licensed as a campus.	0 470			

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0 470	Continued From page 13 DAILY SCHEDULE On January 5, 2026, at 10:42 a.m., the surveyor did not observe a daily work schedule posted in a central location on the 33 side of the duplex. Unlicensed personnel (ULP)-F pointed to the wall next to the dining room table and stated the schedule was normally posted there on the wall and they were waiting for licensed assisted living (LALD)-D to bring in the new schedule. On January 6, 2026, at 9:20 a.m., LALD-D stated, "it is my fault" they were supposed to get the schedules distributed to the facility and did not get the staffing documents to staff members. LALD-D stated they did text the staff schedules to the staff but did not post them. LALD-D stated they normally were not responsible for the staff schedule posting however, right now they were the person responsible for posting them. The licensee's 4.06 Staffing & Scheduling policy dated August 2, 2021, indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. STAFFING PLAN The licensee's undated and unsigned staffing plan titled [licensee name] Staffing Plan Kentucky ½ indicated there were two staff members at the facility on day shift and two awake staff members at the facility at night. In addition, there was an employee for activities and appointments as needed. The staffing plan was not reviewed twice per year and the surveyor was unable to identify	0 470			

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0 470	Continued From page 14 who created the staffing plan. On January 7, 2026, at 10:30 a.m., LALD-D stated owner/registered nurse (O/CNS)-C was not available for interview as they were currently traveling back to the United States from a different country and their plane was located over an ocean. On January 7, 2026, at 10:41a.m., LALD-D stated they were unable to locate other staffing plans. LALD-D stated they were unaware of why the staffing plan was not completed with required information. The licensee's 4.06 Staffing & Scheduling policy dated August 2, 2021, indicated the CNS would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR 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	0 480			

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0 480	Continued From page 15 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 16 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 5, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510			

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0 510	Continued From page 17 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to hand hygiene for one of two employees (unlicensed personnel (ULP)-B). In addition, the licensee failed to have appropriate hand hygiene supplies available. This had the potential to affect to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: SUPPLIES On January 5, 2026, at 10:10 a.m., the surveyor performed hand hygiene at the kitchen sink on the 25 side of the duplex campus and observed	0 510			

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0 510	Continued From page 18 no paper towel to dry hands. The surveyor inquired if there were paper towels the unlicensed personnel (ULP) could provide to the surveyor. ULP-F stated they were "out of" paper towels and were unable to provide the surveyor with one. On January 5, 2026, at 12:15 p.m., the surveyor used the bathroom and observed no paper towel located in the licensee's bathroom on the 25 side of the duplex. HAND HYGIENE On January 6, 2026, at 8:48 a.m., the surveyor observed ULP-B administer oral medication to R2. Without performing hand hygiene after medication administration to R2, ULP-B administered oral medication to R3. ULP-B then washed their hands after medication administration to R3. On January 6, 2026, at 9:24 a.m., during interview with registered nurse (RN)-A and licensed assisted living director (LALD)-D, RN-A stated staff were trained by using EduCare (a training software) and in person for infection control. RN-A stated staff received an in-service on steps of hand handwashing. RN-A stated ULP were trained to perform hand hygiene in between medication passes and in between resident care. LALD-D stated "normally" there were paper towels stored in the closet. LALD-D stated they believed it was an exception that they did not have paper towels to dry hands with. The Centers for Disease Control and Prevention (CDC)'s undated document titled Core Concepts for Hand Hygiene: Clean Hands for Healthcare personnel indicated hand should be dried with a dry disposable towel.	0 510			

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0 510	Continued From page 19 The CDC's document titled Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, indicated hand washing should be performed immediately before touching a patient and after touching a patient or patient's surroundings. The licensee's 8.01 Infection Control Policy dated August 1, 2021, indicated the licensee's infection control program would be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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.	0 550			

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0 550	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place information about the licensee's grievance procedure that included the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's facility was a duplex with two separate addresses. The last two numbers of the addresses were 25 and 33. The licensee was licensed as a campus. On January 5, 2026, at 10:42 a.m., the surveyor observed a posted sign on the licensee's kitchen refrigerator on the 33 side of the campus that read, "FYI: COMPLAINT/GRIEVANCE POLICY AND CONTACT INFORMATION, RESIDENTS DAILY ACTIVITY SCHEDULE AND STAFF DAILY SCHEDULES [sic] ARE IN THE STAFF BINDERS FOR EASY ACCESSABILITY." The surveyor asked to see the staff binder that contained the grievance policy. The surveyor	0 550			

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0 550	Continued From page 21 observed unlicensed personnel (ULP)-F looking for the binder and then contact an unknown person via phone. Housing manager (HM)-J walked into the facility and the surveyor asked them for the staff binder that contained the grievance policy. HM-J stated the licensee no longer used or had a staff binder and everything was completed via RTasks (a documenting software program). On January 5, 2026, at 10:52 a.m., the surveyor observed the 25 side of the campus and observed a grievance posting located above the kitchen table. The grievance posting lacked name, telephone number, and email contact information for the individual(s) responsible for handling resident grievances. On January 6, 2026, at 9:20 a.m., licensed assisted living director (LALD)-D stated they were unaware why the 25 side did not include the required information, and they were unaware why there was not a binder on the 33 side. On January 7, 2026, at 10:30 a.m., LALD-D stated they had not been employed with the licensee for a long period of time. LALD-D stated owner/registered nurse (O/CNS)-C was not available for interview as they were currently traveling back to the United States from a different country and their plane was located over an ocean. The licensee's 2.09 Complaint / Grievance policy dated August 21, 2023, indicated complaints regarding the licensee were resolved in a timely and appropriate manner for employees or residents that had concerns or complaints. The policy did not address the requirement of posting information related to the grievance procedure.	0 550			

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0 550	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display its current assisted living license in the main entrance of the facility. This had the potential to affect all residents, staff, and visitors to the facility. 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 The findings include: The licensee's facility was a duplex with two separate addresses. The last two numbers of the addresses were 25 and 33. The licensee was licensed as a campus. On January 5, 2026, at 10:52 a.m., the surveyor observed the licensee's license posted on the 25 side of the duplex. The license posted had an effective date of June 1, 2024, and an expiration date of May 31, 2025.	0 570			

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0 570	Continued From page 23 On January 6, 2026, at 9:20 a.m., licensed assisted living director (LALD)-D stated they did not realize the license needed to be posted at both addresses. LALD-D stated they assumed owner/clinical nurse supervisor (O/CNS)-C had the license in their office. On January 7, 2026, LALD-D stated residents could walk from the 25 side to the 33 side if they wanted to see postings however, postings should be located on both sides for accessibility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include	0 630			

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0 630	Continued From page 24 the required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on February 7, 2022, and began receiving assisted living services. R1's diagnoses included schizoaffective disorder (a chronic mental health condition characterized by a combination of symptoms from schizophrenia and mood disorders, such as depression or mania), bipolar (a mental health condition characterized by extreme mood swings, including emotional highs or lows), and substance use disorder. R1's Service Plan (Waiver) - Addendum to Contract signed October 16, 2024, indicated R1 received assistance with activities, appointments, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. R1's IAPP dated December 17, 2025, indicated R1 was not at risk to abuse others. R1's IAPP lacked an individualized review or assessment of the resident's susceptibility to be abused by other individuals.	0 630			

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0 630	Continued From page 25 R2 R2 admitted to the licensee on November 5, 2024, and began receiving assisted living services. R2's diagnoses included schizoaffective disorder, anxiety, major depression, post-traumatic stress disorder (PTSD), and epilepsy (a neurological condition characterized by repeated seizures). R2's Service Plan (Waiver) - Addendum to Contract signed November 14, 2024, indicated R2 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. R2's IAPP dated November 4, 2025, indicated R2 was at risk of abusing others and included specific measures to be taken to minimize the risk of abuse towards others. R2's IAPP lacked an individualized review or assessment of the resident susceptibility to be abused by other individuals. R3 R3's admitted to the licensee on September 1, 2024, and began receiving assisted living services. R3's diagnoses included schizophrenia (a mental health disorder that affects how a person thinks, feels, and behaves, often leading to a distorted perception of reality), alcohol use disorder, and major depression. R3's Service Plan (Waiver) - Addendum to Contract signed September 4, 2024, indicated R3	0 630			

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0 630	Continued From page 26 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. R3's IAPP dated November 4, 2025, indicated R3 was at risk of abusing others and included specific measures to be taken to minimize the risk of abuse towards others. R3's IAPP lacked an individualized review or assessment of the resident susceptibility to be abused by other individuals. On January 6, 2026, at 9:20 a.m., licensed assisted living director (LALD)-D stated R1 was not at risk to be abused by others. Registered nurse (RN)-A opened RTasks (a documenting software program) and the surveyor observed there was not an option for the nurse to click on to indicate if residents were not at risk to be abused by others. RN-A stated it was not addressed in the assessment because there was not an option to click on in the assessment. On January 7, 2026, at 12:13 p.m., RN-A acknowledged R1, R2, and R3 assessment lacked a statement if the residents were at risk to be abused. RN-A stated they just found out they could contact RTasks to build more options for responses into the licensee's assessment. The licensees 6.05 Individual Abuse Prevention Plan policy dated January 1, 2022, indicated the IAPP would contain an individualized review or assessment of the person's susceptibility to abuse by another individual. No further information was provided.	0 630			

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0 630	Continued From page 27	0 630			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
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 information: (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 three employees (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 28 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 was hired on March 27, 2025, to provide assisted living services. On January 6, 2026, at 10:17 a.m., licensed assisted living director (LALD)-D provided the surveyor with ULP-B's personnel file and stated the licensee's office was raided by the police department seven months ago and the police department took personnel files for all ULP but left the nurse's personnel files. LALD-D stated the police department had not returned the ULP files to the licensee. LALD-D stated they had to re-create ULP-B's personnel file on January 5, 2025. On January 6, 2025, at approximately 11:35 a.m., licensed assisted living director stated approximately half of the ULP employee records would not have information in them. On January 6, 2026, at 11:06 a.m., during an interview via phone with owner/registered nurse (O/CNS)-C and in person with LALD-D and RN-A, the surveyor inquired why competencies and trainings were not re-done rather than back-dating documents after the personnel records were taken by the police. O/CNS-C stated they referred to sign-in records from previously held in-person trainings, RTasks transcript (a documenting software company),	0 650			

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0 650	Continued From page 29 and an EduCare transcript (training software program). The surveyor requested that O/CNS-C provide evidence to corroborate the specific trainings, competency evaluations, and dates of when the staff member was trained that were utilized to re-create ULP-B's record. O/CNS-C provided an EduCare transcript for ULP-B that showed training completion dates for six of the 22 required training areas and evaluation topics for all ULP (who are not certified nursing assistants). In addition to those six areas, the transcript also included record of dementia training for 1.75 of the required 8 hours and one of the nine required orientation topics (Assisted Living Bill of Rights) with completion dates ranging from March 27, 2025, to April 27, 2025. The record showed no evidence of training on any other delegated tasks or of demonstration of competency evaluation. On January 6, 2026, at 11:41 a.m., ULP-B stated the nurse watched them complete the tasks after they received training. ULP-B stated they received a 30-day supervision from the nurse. On January 7, 2026, at 10:30 a.m., LALD-D stated owner/registered nurse (O/CNS)-C was not available for an additional interview as they were currently traveling back to the United States from a different country and their plane was located over an ocean. The licensee's 5.10 Training Records policy dated August 21, 2021, indicated the licensee would maintain a record of staff training and competencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

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0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-B, licensed practical nurse (LPN)-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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 660			

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0 660	Continued From page 31 a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on March 27, 2025, to provide assisted living services. ULP-B's employee record included Baseline TB Screening Tool for Health Care Workers (HCWs) dated March 25, 2025. The document lacked documentation of TB screening. ULP-B's employee record lacked a two-step TST or other evidence of TB screening such as a blood test. LPN-E LPN-E was hired on August 3, 2022, to provide oversight and supervision to ULP and provide assisted living services. LPN-E's employee record included Baseline TB Screening Tool for Health Care Workers (HCWs) dated September 4, 2023. In addition, LPN-E's record included a QuantiFERON on TB gold test dated November 28, 2021, which indicated LPN-E was negative for TB. LPN-E's employee record lacked a valid TB screening as the TB screening was not completed within 90 days of hire. On January 6, 2026, at 10:17 a.m., licensed assisted living director (LALD)-D stated ULP-B's record would be missing the tuberculosis (TB) test because ULP-B needed to retrieve a copy to be placed in the employee file. On January 6, 2026, at 11:46 a.m., ULP-B stated	0 660			

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0 660	Continued From page 32 they had a TB screen completed at their last place of employment and they were working on obtaining the documentation to provide to the licensee. On January 6, 2025, at approximately 11:35 a.m., LALD-D stated approximately half of the ULP employee records would not have information in them which would include the TB Baseline TB Screening Tool for Health Care Worker (HCWs) and a TB screening due to a police raid that occurred at the facility approximately seven months ago. On January 7, 2026, at 12:14 p.m., registered nurse (RN)-A stated they actively worked on the TB health care screening tools and reviewed TB screens and once they completed and reviewed the documents they would turn the paperwork into owner/clinical nurse supervisor (O/CNS)-C. RN-A stated they believed a QuantiFERON gold could be accepted if it was within three years of the date of hire because other places of employment have taken their TB screen after four years of it being completed. The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; - a TB test which could include TB blood test or TB skin test; and - additional evaluation for TB disease as needed. The Minnesota Department of Health (MDH) Resources and Frequently Asked Questions (FAQs) dated October 13, 2025, indicated TST or	0 660			

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0 660	Continued From page 33 interferon-gamma release assays (IGRAs) could be accepted as an acceptable TB screen if it was dated within 90 days of being hired. The licensee's 8.16 Tuberculosis Screening policy dated January 7, 2026, indicated new staff would have a IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. In addition, TB screening results would be kept in each employee medical file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 34 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP binder titled Emergency Preparedness Program dated September 2022 included the following sections that were not accurate to the licensee's current population: - emergency plan (EP) program patient population - subsistence needs for staff and patients. In addition, the EPP lacked evidence of the following required content: - annual review; - considered emerging infectious diseases; - hazard vulnerability assessment; - strategies for addressing facility and	0 680			

Minnesota Department of Health

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0 680	Continued From page 35 community-based risk which included staffing surges and shortages; - missing resident plan and a review of the missing resident plan quarterly; - transportation in the case of an evacuation; - memorandum of understanding with alternative shelter in case of an evacuation; - communication plan; - names and contact information; - emergency officials contact information; and - emergency prep testing. On January 7, 2026, at 10:30 a.m., licensed assisted living director (LALD)-D stated they had not been employed with the licensee for a long period of time and were not provided access to all of the licensee's records. LALD-D stated owner/registered nurse (O/CNS)-C was not available for interview as they were currently traveling back to the United States from a different country and their plane was located over an ocean. On January 7, 2026, at 10:42 a.m., LALD-D stated they were unable to locate record of drills if the licensee conducted any. LALD-D stated they do not know why substance needs and patient population were not updated when the licensee combined their two previous licenses into one campus. LALD-D stated they did not know the missing resident plan had to be reviewed quarterly, and they did not know why the fill in the blank EPP template was not customized with the licensee's information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

Minnesota Department of Health

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0 775	Continued From page 36	0 775			
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, 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 1/5/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780			

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0 780	Continued From page 37 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: 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	0 780			

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0 780	Continued From page 38 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 1/5/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
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 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	0 790			

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0 790	Continued From page 39 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 1/5/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790			
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	0 800			

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0 800	Continued From page 40 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 1/5/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 or similar emergency; (3) fire protection procedures necessary for	0 810			

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0 810	Continued From page 41 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. 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	0 810			

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0 810	Continued From page 42 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 1/5/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 830			

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0 830	Continued From page 43 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: The licensee's facility was a duplex with two separate addresses. The last two numbers of the addresses were 25 and 33. The licensee was licensed as a campus. On January 5, 2026, at 9:07 a.m., upon arriving to the facility, the surveyor observed R3 smoking in the attached garage with the garage door open on the 25 side of the duplex. On January 5, 2026, at 12:38 a.m., during facility tour, the surveyor observed two unknown males smoking in the garage with the garage door open on the 25 side of the duplex. The surveyor observed three chairs and a metal tin for residents to discard smoking material in. On January 6, 2026, at 9:40 a.m., licensed assisted living director (LALD)-D stated the licensee's designated smoking area was on the porch or outside of the garage in the front yard. LALD-D stated they often have had to "vacate" residents from the garage when they are smoking. LALD-D stated "anytime" they walk through the garage someone is smoking, and it was a challenge for the licensee not to have residents smoke in the garage during winter. The surveyor inquired if the garage was not a designated smoking area why were there chairs	0 830			

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0 830	Continued From page 44 and a place to discard smoking material. LALD-D stated in summer the garage was a "hang out spot" for the residents. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2025, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The Minnesota Department of Health (MDH) document titled Minnesota Clean Indoor Air Act (MCIAA) dated September 7, 2023, indicated an indoor area means a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. In addition, smoking was prohibited at health care facilities and clinics. The licensee's undated Resident Smoking Policy indicated the licensee's facility was a smoke-free facility and smoking would not be allowed in or in front of the facility. Smoking shall take place on the exterior patio located in the back of the facility building. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			

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0 910	Continued From page 45	0 910			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had a Health Facility identification number (HFID) of 34730. R1 R1 admitted to the licensee on February 7, 2022, and began receiving assisted living services.	0 910			

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0 910	Continued From page 46 R1's Assisted Living Contract signed May 12, 2025, indicated the assisted living license number was 34730/34731. R1's contract did not accurately identify the HFID of the licensee. R2 R2 admitted to the licensee on November 5, 2024, and began receiving assisted living services. R2's Assisted Living Contact signed May 12, 2025, indicated R2 resided at the assisted living license number of 34731. R2's contract did not accurately identify the HFID of the licensee. R3 R3 admitted to the licensee on September 1, 2024, and began receiving assisted living services. R3's Assisted Living Contract signed May 12, 2025, indicated R3 resided at the assisted living license number of 34731. R3's contract did not accurately identify the HFID of the licensee. On January 7, 2026, at 10:40 a.m., the surveyor inquired if the contracts were updated with the licensee's new HFID when their previous two assisted living licenses were combined into a campus. Licensed assisted living director (LALD)-D stated the HFID should have been changed in the contract. LALD-D stated they were not aware if the contracts were updated when the two assisted living combined because they were not employed by the licensee at that time. LALD-D acknowledged the HFID was not updated in the contract for R1, R2, and R3. No further information was provided.	0 910			

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0 910	Continued From page 47	0 910			
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 assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on February 7, 2022, and began receiving assisted living services. R2 admitted to the licensee on November 5, 2024, and began receiving assisted living	0 970			

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0 970	Continued From page 48 services. R3 admitted to the licensee on September 1, 2024, and began receiving assisted living services. R1, R2, R3's Assisted Living Contracts all signed on May 12, 2025, included the following language indicating waivers of liability: "Responsibility: [the licensee's name] may not be responsible for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident hold [the licensee] for any claims or damages caused by negligence of [the licensee]." On January 7, 2026, at 10:49 a.m., licensed assisted living director (LALD)-D stated they knew there was language indicating waiver of liability in the contract and they needed to be revised. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
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	01290			

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01290	Continued From page 49 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received an affiliation with the assisted living license for four of five employees (unlicensed personnel (ULP)-B, ULP-G ULP-H, director (D)-I). 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 was hired on March 27, 2025, to provide assisted living services. ULP-G was hired on November 16, 2024, to provide assisted living services. ULP-H was hired on April 25, 2024, to provide assisted living services. D-I was hired on May 22, 2024, to provide	01290			

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01290	Continued From page 50 operational oversight and assisted living services. On January 6, 2025, at 9:20 a.m., licensed assisted living director (LALD)-D stated they received the licensee's NetStudy 2.0 (web-based system used to submit background study requests) rosters from owner/registered nurse (O/CNS-C) because they did not have access to it. LALD-D stated the rosters they received contained two different health identification numbers (HFID) and contained employees who were no longer were employed. LALD-D stated they were going to have O/CNS-C remove people who were no longer employed from the rosters and then would provide the surveyor with the roster. In addition, LALD-D stated they did not believe O/CNS-C knew how to manage the NetStudy Rosters as they were confused when the LALD-D was explaining what was needed for the survey. On January 6, 2026, at 12:01 p.m., LALD-D stated they did not know if employees were affiliated with the licensee's new HFID 34730 in April 2025, when the licensee changed from two licenses and two HFIDs to a campus that held one license and one HFID. On January 6, 2025, at 2:24 p.m., the surveyor received two NetStudy 2.0 rosters via email, from LALD-D with the HFIDs of 34731 and 34730. The licensee's HFID was 34730. On January 7, 2026, at 6:13 a.m., the surveyor compared the licensee's staff roster with both NetStudy 2.0 rosters and did not observe ULP-G, ULP-H, and D-I listed on the 34731 roster or the 34730 roster. In addition, ULP-B was affiliated with HFID 34731 and not HFID 34730.	01290			

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01290	Continued From page 51 On January 7, 2026, at 7:06 a.m., the surveyor observed NetStudy 2.0 and observed the following ULPs affiliated with other companies or license types the licensee owned: - ULP-H affiliated to 1119230; - D-I affiliated to 1119230, HFID 33670, and HFID 32326; and - ULP-G affiliated to 1119230. On January 7, 2026, at 10:30 a.m., LALD-D stated they had not been employed with the licensee for a long period of time and were not provided access to all of the licensee's records. LALD-D stated O/CNS-C was not available for interview as they were currently traveling back to the United States from a different country and their plane was located over an ocean. The licensee's 2.34 Background Checks policy dated August 4, 2016, indicated the licensee would conduct a background study on all employees who would have independent, unsupervised contact with tenants or clients [residents]. The policy did not address affiliating the background studies to the licensee's HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500			

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01500	Continued From page 52 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500			

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01500	Continued From page 53 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment for two of two employees (registered nurse (RN)-A, licensed practical nurse (LPN)-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 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: RN-A RN-A was hired on August 23, 2022, to provide oversight and supervision to unlicensed personnel (ULP) and to provide assisted living services. RN-A's employee record included an EduCare (a training software company) transcript which indicated RN-A received 23.75 hours of training in	01500			

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01500	Continued From page 54 2025. The transcript included abuse prevention, assisted living bill of rights, and a dementia refresher course completed in 2025. RN-A's employee record lacked the following required annual training topics: - infection control techniques; - review of providers policies and procedures; and - principles of person-centered planning/service delivery. LPN-E LPN-E was hired on August 3, 2022, to provide oversight and supervision to ULP and provide assisted living services. LPN-E's employee record included an EduCare transcript. The transcript lacked any training for 2025. The transcript did include the required annual training topics of assisted living bill of rights and infection control that were completed by LPN-E during the survey on January 6, 2026. LPN-E record lacked eight hours of required annual training for every 12 months of employment. LPN-E's record lacked the following required annual training: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control; - effective approaches to use to solve problems when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or other related disorders; - review of providers policies and procedures; and - principle of person-centered planning/service delivery. On January 6, 2026, at 1:10 p.m., licensed assisted living director (LALD)-D stated policies	01500			

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01500	Continued From page 55 and procedures would have been trained in person however, if documentation was not in the employee's record it did not occur. LALD-D stated all other required topics besides the licensee's policies and procedures would be completed via EduCare. On January 7, 2026, at 10:52 a.m., LALD-D stated they had not been employed by the licensee for a long period of time, and they did not know why RN-A and LPN-E did not complete the required training. On January 7, 2026, at 12:20 p.m., RN-A stated annual training was completed via EduCare. RN-A stated they did not know why they did not receive training on the required topics however they would talk with owner/clinical nurse supervisor (O/CNS)-C to add the modules to their EduCare training. The licensee's 5.06 Annual Required Staff Training policy dated January 1, 2022, indicated all staff that performed direct care services would complete at least eight hours of annual training for each 12 months of employment. "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500			

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01500	Continued From page 56 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
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	01530			

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01530	Continued From page 57 employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide two hours of training related to dementia for two of two employees (registered nurse (RN)-A, licensed practical nurse (LPN)-E) and failed to provide one hour of training on topics related to mental illness and de-escalation for one of two employees (LPN)-E for every 12 months of employment. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530			

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01530	Continued From page 58 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: RN-A RN-A was hired on August 23, 2022, to provide oversight and supervision to unlicensed personnel (ULP) and to provide assisted living services. RN-A's employee record included an EduCare (a training software) transcript that included a one-hour dementia refresher course on April 1, 2025. Although RN-A's employee record included one hour of dementia training, RN-A's record lacked one hour of dementia training out of the two hours required for every 12 months of employment. LPN-E LPN-E was hired on August 3, 2022, to provide oversight and supervision to ULP and provide assisted living services. LPN-E's employee record included an EduCare transcript that included mental illness completed July 3, 2024. LPN-E's record lacked two hours of dementia care training for the years 2024 and 2025. In addition, LPN-E's record lacked one hour of mental illness and de-escalation training for 2025. On January 6, 2026, at 12:05 p.m., during an interview with RN-A and licensed assisted living director (LALD)-D, RN-A stated dementia training	01530			

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01530	Continued From page 59 and mental health trainings were completed via EduCare. LALD-D agreed with RN-A. On January 7, 2026, at 10:30 a.m., LALD-D stated owner/registered nurse (O/CNS)-C was not available for interview as they were currently traveling back to the United States from a different country and their plane was located over an ocean. The licensee's 5.03 Dementia Training policy dated August 21, 2021, indicated all staff would complete two hours dementia training for each 12 months of employment. The licensee's policy did not address the mental health training requirement. The licensee's 5.06 Annual Required Staff Training Policy dated January 1, 2022, did not address the mental health training requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01565 SS=C	144G.64 (c) Training in Dementia, Mental Illness, and De- (a)The facility shall provide to consumers in written or electronic form a description of the training program, the categories of staff trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by:	01565			

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01565	Continued From page 60 Based on interview and record review the licensee failed to provide consumers in written or electronic form a description of the training program, the categories of staff trained, the frequency of training, and the basic topics covered. 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 The findings include: On January 5, 2026, at 12:02 p.m., the surveyor requested the licensee's descriptions of training program for dementia care. On January 6, 2026, at 6:00 a.m., via email, licensed assisted living director (LALD)-D wrote, "We do not currently have an information sheet on our dementia care program. I'm aware this is required and will create one." The licensee's 5.03 Dementia Training policy dated August 21, 2021, indicated the licensee would provide consumers a written or electronic description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01565			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620			

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01620	Continued From page 61 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse 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	01620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER EMPATHY HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7333 KENTUCKY AVENUE NORTH BROOKLYN PARK, MN 55428			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 62 be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 admitted to the licensee on November 5, 2024, and began receiving assisted living services. R2's diagnoses included schizoaffective disorder (a chronic mental health condition characterized by a combination of symptoms from	01620			

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01620	Continued From page 63 schizophrenia and mood disorders, such as depression or mania), anxiety, major depression, post-traumatic stress disorder (PTSD), and epilepsy (a neurological condition characterized by repeated seizures). R2's Service Plan (Waiver) - Addendum to Contract signed November 14, 2024, indicated R2 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. R3 R3's admitted to the licensee on September 1, 2024, and began receiving assisted living services. R3's diagnoses included schizophrenia (a mental health disorder that affects how a person thinks, feels, and behaves, often leading to a distorted perception of reality), alcohol use disorder, and major depression. R3's Service Plan (Waiver) - Addendum to Contract signed September 4, 2024, indicated R3 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. R2 and R3's records included ongoing assessments dated April 28, 2025, August 18, 2025, and November 4, 2025, indicating 112 days passed between the April and the August assessments. On January 7, 2026, at 10:30 a.m., licensed	01620			

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01620	Continued From page 64 assisted living director (LALD)-D stated owner/registered nurse (O/CNS)-C was not available for interview as they were currently traveling back to the United States from a different country and their plane was located over an ocean. On January 7, 2026, at 12:22 p.m., registered nurse (RN)-A stated, "I cannot speak to why they were late." The licensee's 6.02 Assessment Schedules policy dated January 7, 2026, indicated ongoing resident reassessment and monitoring would occur as needed based on changes in the needs of the resident but could not exceed 90 calendar days from the date of the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided;	01730			

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01730	Continued From page 65 (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for one of three residents (R3). This practice resulted in a level two violation (a	01730			

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01730	Continued From page 66 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the licensee on September 1, 2024, and began receiving assisted living services. R3's diagnoses included schizophrenia (a mental health disorder that affects how a person thinks, feels, and behaves, often leading to a distorted perception of reality), alcohol use disorder, and major depression. R3's Service Plan (Waiver) - Addendum to Contract signed September 4, 2024, indicated R3 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. On January 6, 2026, at 9:08 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medication to R3. R3's ongoing assessment dated November 4, 2025, indicated staff would administer all of R3's medications, the nurse was responsible for monitoring medication supplies and reordering as needed, R3's medications were securely locked in the medication cabinets, medication management tasks for R3 that may be delegated	01730			

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01730	Continued From page 67 to ULP included oral medications, and a nurse's number was posted in the facility for staff to call the nurse if questions or concerns arose related to R3's medications. R3's Med Admin Summary - Actual - Month dated January 2026, included acetaminophen 500 mg take one to two tabs by mouth every six hours as needed for mild pain. The medication administration record (MAR) did not indicate when one tablet vs two tablets of acetaminophen should be administered. R3's medication management plan comprised of multiple documents lacked specific written instructions for the resident's medication administration. On January 7, 2026, at 12:27 p.m., registered nurse (RN)-A stated they believed R3 instructed the ULP on how many tablets of acetaminophen to administer. RN-A stated the medication order should have been separated into two different orders, so the ULP knew how to administer the medication. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated January 6, 2026, indicated when administration of medications was delegated to the ULP, the licensee would ensure that the registered nurse has specified, in writing, specific instructions each resident and documented those instructions in the resident records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

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01760	Continued From page 68	01760			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document each medication administered by the assisted living facility staff or failed to document on why the medication administration was not completed as prescribed for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01760			

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01760	Continued From page 69 R1 R1 admitted to the licensee on February 7, 2022, and began receiving assisted living services. R1's diagnoses included schizoaffective disorder (a chronic mental health condition characterized by a combination of symptoms from schizophrenia and mood disorders, such as depression or mania), bipolar (a mental health condition characterized by extreme mood swings, including emotional highs or lows), and substance use disorder. R1's Service Plan (Waiver) - Addendum to Contract signed October 16, 2024, indicated R1 received assistance with activities, appointments, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. R1's Med Admin Summary - Actual - Month dated December 2025 lacked any documentation for the following medications: - amphetamine salts 30 milligrams (mg) at 8:00 a.m., on December 1, 3, 4, 12, 13, 17, 18, 28, 29, 30, and 31, 2025; and - metoprolol succinate extended release (ER) at bedtime on December 4, 6, 15, 16, 21, 22, 30, and 31, 2025. R2 R2 admitted to the licensee on November 5, 2024, and began receiving assisted living services. R2's diagnoses included schizoaffective disorder (a chronic mental health condition characterized by a combination of symptoms from schizophrenia and mood disorders, such as depression or mania), anxiety, major depression,	01760			

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01760	Continued From page 70 post-traumatic stress disorder (PTSD), and epilepsy (a neurological condition characterized by repeated seizures). R2's Service Plan (Waiver) - Addendum to Contract signed November 14, 2024, indicated R2 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. R2's Med Admin Summary - Actual - Month dated December 2025 lacked any documentation for the following medications scheduled at 8:00 a.m., on December 25, and 26, 2025: - cetirizine 10 mg; - gabapentin 600 mg; - metformin 500 mg; - naltrexone 50 mg; - olanzapine 10 mg; - quetiapine 100 mg; and - quetiapine 25 mg. In addition, on December 25, and 26, 2025, the following 4:00 p.m., and 5:00 p.m., medications lacked any documentation: - gabapentin 600 mg; - levetiracetam 500 mg; - quetiapine 100 mg; - quetiapine 25 mg; and - vitamin D3 50 micrograms (mcg). R3 R3's admitted to the licensee on September 1, 2024, and began receiving assisted living services. R3's diagnoses included schizophrenia (a mental health disorder that affects how a person thinks, feels, and behaves, often leading to a distorted	01760			

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01760	Continued From page 71 perception of reality), alcohol use disorder, and major depression. R3's Service Plan (Waiver) - Addendum to Contract signed September 4, 2024, indicated R3 received assistance with activities, appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, socialization, transportation, and shopping. R3's Med Admin Summary - Actual - Month dated December 2025 lacked any documentation for the following medications: - benztropine 1 mg on December 25, 2025; - atomoxetine 60 mg on December 26, 2025; - tab-a-vite one tablet on December 26, 2025; - vitamin C 500 mg on December 26, 2025; and - vitamin D3 1000 units (u) on December 26, 2025. R1, R2, and R3's medication administration records (MAR)s did not include documentation for the medications listed above if they were administered or not administered by the licensee's staff members. On January 6, 2026, at 9:45 a.m., during an interview with licensed assisted living director (LALD)-D and registered nurse (RN)-A, LALD-D stated RTasks (a documenting software program) did not allow documentation on a medication if they were outside of the one-hour administration window. RN-A stated they believed R1, R2, and R3 received their medication however, due to RTasks it did not allow the unlicensed personnel (ULP) to document on the medication if it was after the hour cut off (if medication was scheduled at eight, they were allowed to document from seven to nine). LALD-D stated it	01760			

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01760	Continued From page 72 was an issue the licensee noticed and have been asking prescribers to expand their administration time because of the documentation issue. The licensee's 7.22 Medication & Treatment Record - Documentation and Refusal policy dated February 1, 2023, indicated documentation of medication administration would be completed by the person who performed the task immediately after the medication administration was completed. In addition, if a medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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 discard expired medication for five of eight residents (R1, R2, R3, R4, R5). This practice resulted in a level two violation (a	01890			

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01890	Continued From page 73 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: The licensee's facility was a duplex with two separate addresses. The last two numbers of the addresses were 25 and 33. The licensee was licensed as a campus. On January 5, 2026, at 10:10 a.m., the surveyor observed the licensee's medication file cabinet located on the 25 side of the facility and observed the following expired medications: - R2 naloxone hydrochloride (HCL) 4mg with and expiration date of November 14, 2025, Milk of Magnesium with an expiration date of November 26, 2025, nicotine 2 mg mint lozenge with an expiration date of December 18, 2025, acetaminophen 500 mg tablets with an expiration date of November 26, 2025, two cards of stool softener 8.6 mg- 50 mg with an expiration date of November 26, 2025, ondansetron 4 mg with and expiration date of October 28, 2025, two cards of tizanidine 2 mg with an expiration date of October 28, 2025, and Clearlax powder 17 gm with an expiration date of November 26, 2025; - R3 naloxone HCL 4 mg with an expiration date of November 13, 2025, and olanzapine 2.5 mg with and expiration date of November 19, 2025; and - R4 naloxone HCL 4 mg with an expiration date of October 10, 2025, pain reliever plus tablets with an expiration date of December 17, 2025,	01890			

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01890	Continued From page 74 and ondansetron 4 mg with an expiration date of November 26, 2025. On January 5, 2025, at 10:35 a.m., the surveyor observed the licensee's medication file cabinet located on the 33 side of the facility and observed the following expired medications: - R1 nicotine 4 mg gum with an expiration date of December 11, 2024, and two boxes of Invega Trinza with an expiration date of December 4, 2025; and - R5 one bottle of Neo-Poly-Dex0.1% ointment with an expiration date of October 10, 2025. On January 5, 2026, at 10:31 a.m., unlicensed personnel (ULP)-B stated the nurses normally went through the medication file cabinet and removed expired medications. On January 6, 2026, at 9:47 a.m., registered nurse (RN)-A stated they audited the licensee's medication file cabinets once per month with cycle refills to check for expiration dates and supplies. RN-A stated they also may audit medication file cabinets if new medications arrived from pharmacy. RN-A stated they were unaware of the expired medications and would remove them from the medication file cabinets. The licensee's undated 7.23 Medication Disposal indicated the facility shall dispose medication remaining within the facility that were expired according to the state and federal regulation for disposition of medications and controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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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

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Establishment Info

EMPATHY HOME CARE INC
7333 KENTUCKY AVENUE NORTH
Brook Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34730

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1018261002
Inspection Type: Full - Single
Date: 1/5/2026 Time: 3:07:08 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery:

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: No certified food protection manager on site. Comply with rule.

Comply By: 3/1/2026 Originally Issued On: 1/5/2026

! 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: Establishment is not currently keeping an illness log for employees. Comply with rule.

Comply By: 1/5/2026 Originally Issued On: 1/5/2026

! 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: In both kitchens, eggs were observed to be stored over ready to eat foods. comply with rule.

Comply By: 1/5/2026 Originally Issued On: 1/5/2026

New Order: 4-200 Equipment Design and Construction

4-201.11GMN Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: In both kitchens, leftovers are being saved and served again. Discussed with staff that they may only do same day service of foods. Comply with rule.

Comply By: 1/5/2026 Originally Issued On: 1/5/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-702.11 Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

COMMENT: In both houses, the dishwashers are not in use. Dishes are only being cleaned with dish soap. Discussed proper washing, rinsing, and sanitizing of dishes with staff and discussed that they should begin using the dishwashers for proper cleaning of dishes.

Comply By: 1/5/2026 Originally Issued On: 1/5/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: In kitchen on the left side of the duplex, an outlet cover is missing, and a cabinet door above the sink is missing.
Comply with rule.

Comply By: 1/5/2026 Originally Issued On: 1/5/2026

Food & Beverage General Comment

Establishment is a duplex house with kitchens on both sides. Both kitchens are under the same license and both were inspected during today's inspection.

Both kitchens are residential with residential equipment.

Equipment was observed in good condition.

Discussed pest control.

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 F1018261002 from 1/5/2026

Isaac Quayson
Person in Charge



Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
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Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

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Establishment Info

EMPATHY HOME CARE INC
Brook Park
County/Group: Hennepin County

Inspection Info

Report Number: F1018261002
Inspection Type: Full
Date: 1/5/2026
Time: 3:07:08 PM

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

Location: cooler
at 40 Degrees F.

Comment:

Violation Issued?: No

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

Location: cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34730016	Date: 1/5/2026
Facility Name: Empathy Home Care Inc	
Facility Address: 7333 Kentucky Ave N, Brooklyn Park, MN 55428	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: In the 7325 building, there were missing hard-wired smoke alarms in the following locations: resident room 3, resident room 4, and outside of resident room 4.

2. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

Comments: In resident room 2 in the 7333 building, there was a power strip that was plugged into second power strip that was plugged into a third power strip.

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: In resident room 3 in the 7325 building, there was no smoke alarm installed. In resident room 1 in the 7333, building there was no smoke alarm installed.

2. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: In building 7325, there was no smoke alarm installed outside of resident sleeping room 4.

3. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested that licensed assisted living director (LALD)-D test the smoke alarms during facility tour. Smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: Service tags on the fire extinguishers in both buildings indicated that it was more than 1 year since they were last serviced. The fire extinguishers lacked 30 day checks by facility staff. The fire extinguishers were not hung up. Portable fire extinguishers shall be permanently mounted in a conspicuous location at least four inches off the floor and no higher than five feet above the floor to the top of the extinguisher.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

Comments:

*The following maintenance issues were discovered in the **7325 building**:*

There was a missing outlet cover in the kitchen to the left of the sink.

resident room 1 was missing a light globe.

The first floor bathroom door handle was loose and would not lock.

The strike side and top of the door frame for resident room 2 was missing.

The closet doors were off in resident room 2.

The floor drain in the mechanical room was backing up causing water from the washing machine to back up on to the floor.

*The following maintenance issues were discovered in the **7333 building**:*

Resident room 1 was missing a light globe.

The first floor bathroom door had a hole in it.

The bottom door hinge of resident room 3 was not secured to the door frame.

The bathroom door in the lower level was split at the bottom.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step.

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 policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.