Electronically Delivered

February 18, 2026

Licensee
CareServices LLC
3005 Mary Court
Little Canada, MN 55109

RE: Project Number(s) SL36920016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36920	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARESERVICES LLC	3005 MARY COURT LITTLE CANADA, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#36920016 On January 20, 2026, through January 22, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living director (ALD) had a current and active license with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents receiving Assisted Living services. 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 20, 2026, at approximately 10:00 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated ALD-A was on vacation and not available for the survey. CNS-B also stated ALD-A was the licensed ALD-A for the licensee. On January 20, 2026, at approximately 2:05 p.m., the surveyor reviewed BELTSS license verification website with CNS-B. BELTSS website	0 110		

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0 110	Continued From page 2 indicated ALD-A's license expired on October 31, 2025. On January 20, 2026, at approximately 2:10 p.m., CNS-B stated they were not aware ALD-A's license had expired and would communicate with ALD-A to work on obtaining a renewed ALD license. The licensee's 4.01 Assisted Living Director policy dated July 22, 2022, indicated the licensee's ALD would maintain a current and active license with BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 110		
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	0 470		

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0 470	Continued From page 3 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 and interview, the licensee failed to ensure the clinical nurse supervisor (CNS) reviewed the staffing plan at least twice a year and to ensure a current staffing schedule was posted as required potentially affecting all the licensee's current 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 held an assisted living facility license for a capacity of 4 (four) residents and had a current census of 3 residents. STAFFING PLAN On January 20, 2026, at approximately 10:15 a.m., during the entrance conference, CNS-B stated the licensee reviewed the staffing plan	0 470		

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0 470	Continued From page 4 twice a year. On January 20, 2026, at approximately 10:25 a.m., CNS-B provided a binder and stated the contents were the licensee's staffing plan records. The licensee's staffing binder indicated July 8, 2024, and December 12, 2024, were the last two dates that the licensee's staffing plan was reviewed by the licensee. On January 12, 2026, at approximately 10:35 a.m., CNS-B stated the licensee had reviewed the staffing plan in the past and was unsure why the staffing plan had not been reviewed since 2024. STAFF SCHEDULE On January 20, 2026, at approximately 10:45 a.m., during a tour of the facility, the surveyor observed in the upper-level kitchen, a large one-month calendar whiteboard that indicated the month of January and no other information was provided. On January 20, 2026, at approximately 10:50 a.m., CNS-B stated the whiteboard was the licensee's posted staff schedule. CNS-B also stated the licensee recently cleaned the whiteboard and had not updated the whiteboard with the current staff schedule. The licensee lacked a current posted daily staffing schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. The licensee's 4.06 Staffing and Scheduling policy, dated July 22, 2021, indicated the licensee	0 470		

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0 470	Continued From page 5 would develop and post a daily staffing schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not	0 480		

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0 480	Continued From page 6 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. 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	0 480		

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0 480	Continued From page 7 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 20, 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		
0 570 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 the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. 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 the potential to affect a large portion or all the residents).	0 570		

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0 570	Continued From page 8 The findings include: The licensee held an assisted living license effective August 1, 2025, with an expiration date of July 31, 2026. On January 20, 2026, at 10:40 a.m., during the facility tour with clinical nurse supervisor (CNS)-B, the surveyor observed the facility's main entrance with a landing and stairs leading both up and down. Surveyor also observed the licensee had posted an expired assisted living facility license in the facility's dining room area next to the sliding door that leads to the back yard deck on the upper level. The date of the license posted was expired on July 31, 2025. On January 20, 2026, at 10:45 a.m., CNS-B acknowledged the licensee's posted license was expired and stated they thought the new license was posted and were aware a current license should be displayed. CNS-B also stated they were unaware that the license should be posted by the main entrance. The licensee's 2.04 Assisted Living License and Posting policy dated July 22, 2021, indicated the licensee would post a current assisted living license by the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant	0 580		

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0 580	Continued From page 9 to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 20, 2026, at approximately 10:20 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee implemented a QMP but was not sure when the last time the licensee's QMP was maintained. CNS-B could not identify a QMP project that the	0 580		

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0 580	Continued From page 10 licensee was currently working on. On January 20, 2026, at approximately 12:05 a.m., CNS-B provided a document and stated this was the licensee's most current QMP meeting minutes. The licensee's Quality Management document dated November 19, 2024, indicated there was no QMP project that the licensee currently had in place. The licensee's 2.31 Quality Management Project policy dated July 22, 2021, indicated the licensee would have always at least one QMP project in place and documentation would be provided upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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.	0 630		

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0 630	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R2). 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: R2 was admitted on November 15, 2022. On January 20, 2026, at approximately 1:30 p.m., clinical nurse supervisor (CNS)-B stated R2's IAPP was included in R2's Assessment. R2's Assessment dated November 20, 2025, indicated R2 was at risk to be abused and did not include: -the resident's susceptibility to abuse by another individual, including other vulnerable adults; -the resident's risk of abusing other vulnerable adults; and -statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On January 20, 2026, at approximately 2:15 p.m., CNS-B confirmed R2's IAPP did not address the above noted areas of risk or include statements of specific measures to be taken to minimize	0 630		

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	36920	A. BUILDING: _____ B. WING _____	01/22/2026

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0 630	Continued From page 12 risks. CNS-B stated the licensee was unaware of the required contents of the IAPP and the IAPPs for all the residents of the licensee would be the same. The licensee's 6.05 Individual Abuse Prevention Plan policy dated July 22, 2021, indicated the licensee would develop and implement IAPPs that included the resident's susceptibility to be abused by another individual, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, and specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	0 640		

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0 640	Continued From page 13 Based on observation, interview, and record review, the licensee failed to post required content to include the 911 emergency number in common areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 20, 2026, at approximately 10:45 a.m., during the facility tour, the surveyor observed the main areas of the facility with clinical nurse supervisor (CNS)-B. The surveyor did not observe the 911 emergency number posted near one (1) cordless telephone. The cordless telephone was located behind a television (TV) on a TV stand in the lower-level living room. On January 20, 2026, at approximately 10:47 a.m., CNS-B stated the cordless telephones could be used by staff, residents, or visitors. On January 20, 2026, at approximately 10:50 a.m., CNS-B stated the licensee was unaware of the requirement for the 911 emergency number to be posted near the cordless telephones in the common areas. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy	0 640		

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0 640	Continued From page 14 dated July 22, 2021, indicated the licensee would post the 911 emergency number in common areas and near telephones provided by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 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 establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment.	0 660		

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0 660	Continued From page 15 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 20, 2026, at approximately 10:15 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee had not completed a recent facility TB risk assessment. On January 20, 2026, at approximately 10:25 a.m., CNS-B provided a binder and stated the contents were the licensee's facility TB risk assessment records. The licensee's infection control binder indicated June 2023, was the last date the licensee's facility TB risk assessment was completed by the licensee. On January 20, 2026, at approximately 10:30 a.m., CNS-B stated the licensee was aware of the TB risk assessment requirement but forgot to complete the last two TB risk assessments. The licensee's 8.16 Tuberculosis Screening policy dated July 22, 2021, indicated the licensee would complete a facility TB risk assessment annually. The Minnesota Department of Health (MDH)	0 660		

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0 660	Continued From page 16 guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. 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 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.	0 680		

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0 680	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 20, 2026, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-B provided a binder and stated the contents were the licensee's EPP. The licensee's EPP dated May 19, 2025, lacked an individualized plan to include all the required content below: -annual review for 2024; -missing resident quarterly reviews; -subsistence needs for staff and residents; -procedures for tracking of staff and residents; -policies and procedures including evacuation; -policies and procedures for sheltering; -policies and procedures for medical documents; -policies and procedures for volunteers; -arrangement with other facilities; -role under a waiver declared by secretary; -methods for sharing information;	0 680		

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0 680	Continued From page 18 -sharing information on occupancy/needs; -LTC family notifications; and -EPP prep testing requirements. On January 20, 2026, at approximately 3:00 p.m., CNS-B acknowledged the licensee's EPP lacked the above listed required content. CNS-B stated the licensee was still learning all the EPP requirements and would update the EPP with the required information. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated August 1, 2021, indicated the licensee would review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=D	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	0 775		

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0 775	Continued From page 19 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1/20/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
0 780 SS=C	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	0 780		

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0 780	Continued From page 20 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 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 the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1/20/2026, for the specific violations related the physical environment under Minnesota Statute	0 780		

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0 780	Continued From page 21 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) 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 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).	0 790		

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0 790	Continued From page 22 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1/20/2026, 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=B	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, 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 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved,	0 800		

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0 800	Continued From page 23 or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1/20/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 24 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 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 1/20/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810		

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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 one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted on November 15, 2022. On January 20, 2026, at approximately 1:50 p.m., clinical nurse supervisor (CNS)-B provided R2's Assisted Living Contract and stated the contract was used by the licensee for all residents who would live in the facility.	0 910		

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0 910	Continued From page 26 R2's Assisted Living Contract dated November 25, 2022, lacked inclusion of the licensee's Health Facility Identification (HFID) number. On January 30, 2026, at approximately 2:30 p.m., CNS-B stated the licensee was not aware of the requirement to have the HFID number on the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety)	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36920	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARESERVICES LLC	3005 MARY COURT LITTLE CANADA, MN 55109

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0 970	Continued From page 27 and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 20, 2026, at approximately 1:50 p.m., clinical nurse supervisor (CNS)-B provided R2's Assisted Living Contract and stated the contract was used by the licensee for all residents who would live in the facility. The licensee's Assisted Living Contract dated November 25, 2025, on page 15, included a section titled Indemnification and read, "Resident will indemnify and hold harmless [licensee], its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property...". The licensee's Assisted Living Contract dated November 25, 2025, on page 15, included a section titled Liability and read, "Provider is not liable to Resident... for any injury, death or property damage...". On January 20, 2026, at approximately 2:35 p.m., CNS-B acknowledged the licensee's assisted living contract included a waiver of liability for health and safety or personal property of the resident. CNS-B stated the liability waiver would need to be removed from the licensee contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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	36920	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARESERVICES LLC	3005 MARY COURT LITTLE CANADA, MN 55109

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01530	Continued From page 28	01530		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the 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	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36920	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARESERVICES LLC	3005 MARY COURT LITTLE CANADA, MN 55109

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01530	Continued From page 29 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 ensure an employee received at least two hours of dementia care training annually as required for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 included: ULP-C had a hire date of October 12, 2021. ULP-C's training record lacked evidence of two hours of dementia care annual training for 2022, 2023, and 2024. On January 20, 2026, at 2:20 p.m., clinical nurse supervisor (CNS)-B stated was unsure why ULP-C did not complete the required annual dementia training for 2022, 2023, and 2024. CNS-B also stated the licensee would ensure all the required annual training for employees would be completed. The licensee's 5.03 Dementia Training policy	01530		

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01530	Continued From page 30 dated July 22, 2021, indicated the required dementia trainings would be completed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 31 the licensee and the resident or resident's designated representative to document agreement on the services to be provided for one of one resident (R2). 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: R2 was admitted on November 15, 2022. On January 20, 2026, at 1:30 p.m., R2's Service Plan dated November 20, 2024, was provided by clinical nurse supervisor (CNS)-B and indicated as R2's current service plan with services R2 was receiving. R2's Service Plan was signed or authenticated by R2's designated representative but was not signed or authenticated by the licensee's representative. On January 20, 2026, at approximately 2:30 p.m., CNS-B confirmed R2's Service Plan was not signed by the licensee. CNS-B stated the licensee was aware that resident's service plans need to be signed by the resident or resident's representative and the licensee. CNS-B also stated the licensee thought R2's service plan was signed and was unsure why R2's service plan was not signed.	01640		

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01640	Continued From page 32 The licensee's 6.08 Service Plan policy dated July 22, 2021, indicated the initial service plan, and any revisions to the resident's service plan would be signed by the resident or the resident's representative and the licensee's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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

Food & Beverage Inspection Report

Establishment Info

CARESERVICES LLC
3005 Mary Court
Maplewood, MN 55109
Ramsey County
Parcel:

Phone:

License Info

License: HFID 36920

Risk:
License:
Expires on:
CFPM: NAIMO ABDISALAM
CFPM #: 113015; Exp: 9/13/2025

Inspection Info

Report Number: F8058261024
Inspection Type: Full - Single
Date: 1/20/2026 Time: 10:29:02 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

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: POSTED CFPM IS EXPIRED
Comply By: 3/31/2026 Originally Issued On: 1/20/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: DISH MACHINE DOES NOT REACH REQUIRED 160 DF (150 RECORDED BY THERMAL STRIP - PHOTO RECEIVED BY TEXT) TESTED AT HIGHEST TEMP SETTING - REPAIR OR REPLACE UNIT
Comply By: 2/13/2026 Originally Issued On: 1/20/2026

Food & Beverage General Comment

HRD INSPECTOR CARL SAMROCK

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

40 TOMATO - COOLER

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 F8058261024 from 1/20/2026

NAIMO ABDISALAM
OWNER

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36920016	**Date:** 1/20/2026
Facility Name: Careservices LLC	
Facility Address: 3005 Mary Court, Maplewood MN 55109	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Two (2) days

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

2. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: There was an extension cord in the kitchen that was powering the microwave. The extension cord ran through and behind the cabinet.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. 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 facility was equipped with two smoke alarms in all required locations. There were hard wired smoke alarms in the common hallway on both floors, and battery operated smoke alarms in the resident rooms. There were interconnected smoke alarms that were installed in all the required locations that were not interconnected with the battery operated smoke alarms installed in the resident rooms or the hard wired smoke alarms in the common hallways.

☒ **TAG IDENTIFICATION: 0790**

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

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

   Comments: The tags on the fire extinguishers showed that they were last serviced in February 2024. The tag lacked documentation that staff were performing 30 day checks of the fire extinguishers.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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 closet doors in resident room 2 were no longer secured and were leaning into the closet.

   In the kitchen there was a missing cabinet door front, and a missing drawer front.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The FSEP 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 the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.

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.

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

   Comments: During record review clinical nurse supervisor (CNS)-B stated that staff training was done in a third party online software, and not on the facilities FSEP.

4. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: During record review CNS-B stated that they were not aware of any resident training documentation on the FSEP.