Electronically Delivered

January 16, 2026

Licensee
Ultimate Care Assisted Living - Brookdale House
3609 78th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34357016

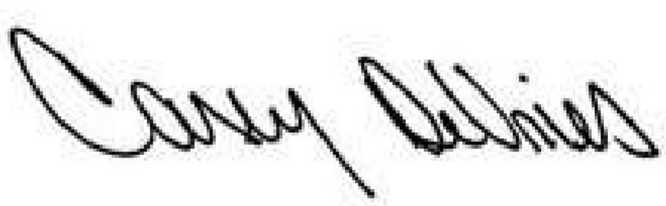
Dear Licensee:

On January 7, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 23, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

HHH

Electronically Delivered

November 14, 2025

Licensee
Ultimate Care Assisted Living - Brookdale House
3609 78th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34357016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $1,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34357	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING BROOKDA	3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER 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: SL34357016-0 On October 20, 2025, through October 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license. An immediate correction order was identified on October 22, 2025, issued for SL34357016-0, tag identification 0470 and 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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=I	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (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; (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 staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs of the residents. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 470		

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0 470	Continued From page 2 not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 October 22, 2025, the licensee had a census of three residents. R2 R2 was admitted August 26, 2025, to receive assisted living services. R2's diagnosis included generalized muscle weakness and diabetes mellitus. R2's record lacked documentation of a completed service plan. R2's admission assessment dated August 28, 2025, indicated R2 required assistance with transfers, and would require the use of a Hoyer lift or easy stand. R2's Home Health Aide Care Plan dated August 28, 2025, indicated R2 would need assistance from 1-2 staff using a Hoyer lift or easy stand lift. On October 21, 2025, the surveyor observed unlicensed personnel (ULP)-C administer medications to R2 in bed at 7:40 am., and again on October 21, 2025, at 8:20 a.m. R3 R3 was admitted April 16, 2019, and began receiving assisted living service on August 1,	0 470		

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0 470	Continued From page 3 2021. R3's diagnosis included paraplegia. R3's service plan dated May 1, 2025, indicated R3 received assisted living services to include bathing, oral cares, skin care, assistance with medications, dressing changes, vital signs, stand by assist with transfers, meal preparation, catheter care, and laundry. R3's initial admission assessment dated July 1, 2024, indicated R3 was non ambulatory and wheelchair bound, as well a double amputee. Additionally, the assessment indicated R3 needed supervision and oversight during transfers. R3's most recent 90-day assessment dated September 27, 2025, indicated no change from their prior admission assessment. On October 21, 2025, at 7:59 a.m., the surveyor observed ULP-C administer morning medications to R3 in bed. R4 R4 was admitted September 17, 2019, and began receiving assisted living services on August 1, 2021. R4's diagnosis included cerebral infarction, anxiety disorder, chronic kidney disease, chronic venous hypertension, difficulty in walking, and essential hypertension. R4's service plan dated May 1, 2024, indicated R4 received assisted living services to include bathing, oral cares, assistance with activities, assistance with transfers, range of motion, meal preparation, partial assist with feeding, toileting,	0 470		

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0 470	Continued From page 4 laundry, medication management, and administration. R4's most recent 90-day assessment dated May 18, 2025, indicated R4 was totally dependent with transfers. R4's most recent 90-day assessment dated September 15, 2025, indicated no change from the prior assessment. The licensee's undated, and unsigned staffing plan indicated for day shift, 7:00 a.m. to 3:00 p.m., the facility would have one home health aide (HHA), one registered nurse (RN), and one lead staff. On evenings, 3:00 p.m., 11:00 p.m., the licensee would have one HHA and one person in charge. On overnights, 11:00 p.m., to 7:00 a.m., the licensee would have one HHA. The licensee's weekly staffing schedule dated October 20, 2025, to November 2, 2025, indicated only one staff member would be scheduled from 11:00 p.m. to 7:00 a.m. On October 21, 2025, at 1:03 p.m., ULP-C stated they typically needed another staff member to get R2 out of bed and stated they would have difficulty in safely transferring R2 using the licensee's Hoyer lift alone. Additionally, ULP-C stated there were supposed to be two staff on for the day and evening shifts, but there was typically only one staff member working. ULP-C stated during shift changes they would utilize an overnight staff member to assist with getting R2 out of bed. On October 22, 2025, at 11:57 a.m., licensed assisted living director (LALD)-A stated that R2 was a one-to-two-person transfer, and there would need to be a second person for transfers for R2 to be able to safely transfer at times of	0 470		

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0 470	Continued From page 5 increased weakness. On October 22, 2025, at 3:39 p.m., the surveyor asked ULP-C how they would transfer and evacuate all three of the licensee's current residents in the event of a fire. ULP-C stated R2 was always a two-person transfer, and they would need to call for help. ULP-C stated R3 would take less time to transfer as they are more independent, but they required stand-by assistance, and R4 required a lot of assistance to transfer and, "I would need help in moving them into their chair". The licensee's Staffing policy dated February 17, 2022, indicated the clinical nurse supervisor would prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	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	0 480		

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0 480	Continued From page 6 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 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 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 20, 2025, 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 nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 8 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 gloving and hand hygiene for one of three 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 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-C was hired November 1, 2024, to provide assisted living services. On October 21, 2025, at 7:39 a.m., the surveyor observed ULP-C enter the room of R2 while wearing gloves to administer morning treatments. At 7:42 a.m., ULP-C removed their gloves and returned supplies to the storage cabinet. At 7:43 a.m., ULP-C put on a new set of gloves without	0 510		

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0 510	Continued From page 9 completing hand hygiene and entered the room of R3 to assist with housekeeping services. At 7:45 a.m., after completing housekeeping services, ULP-C removed gloves, and at 7:46 a.m., without completing hand hygiene, put on a new set of gloves. At 7:48 a.m., the surveyor observed ULP-C remove their gloves and without completing hand hygiene put on a new set of gloves , before beginning preparation of R3's morning medication. At 7:58 a.m., after completing preparation of R3's morning medications, ULP-C again changed their gloves without completing hand hygiene and then went to the room of R3 to administer morning medications. At 7:59 a.m., after completing administration of medications, ULP-C again removed gloves and did not complete hand hygiene. At 8:01 a.m., the surveyor observed ULP-C retrieve morning medications for R2 and put on a new set of gloves without completing hand hygiene. After completing set up of R2's morning medications, at 8:17 a.m., ULP-C again changed their gloves without completing hand hygiene. At 8:21 a.m., after completing administration of R2's morning medications, ULP-C removed gloves without completing hand hygiene, and at 8:22 a.m., put on new gloves and then returned medication administration supplies to the storage cabinet. On October 21, 2025, at 8:29 a.m., ULP-C stated they had worked in the facility for around a year, and they had received training from the registered nurse at their time of hire. ULP-C stated infection control was included in their training. On October 23, 2025, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated all staff were trained to complete hand hygiene before, after, and in between glove changes.	0 510		

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0 510	Continued From page 10 The licensee's Infection Control policy dated February 17, 2022, in indicated the licensee would observe recommended precautions for assisted living as identified by the Centers for Disease Control and Prevention (CDC). The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated November 29, 2022, under section 5a.2 (a, b, c, d, e, f) read: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 570		

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	34357	A. BUILDING: _____ B. WING _____	10/23/2025

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0 570	Continued From page 11 by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living licensure effective February 1, 2025, with an expiration date of January 1, 2026. On October 20, 2025, at 11:01 a.m., during a tour of the facility, the surveyor observed the licensee had a photocopy of the Assisted Living Facility license posted near the main entrance. On October 20, 2025, at 11:15 a.m., licensed assisted living director (LALD)-A stated the original license was at their central office and the one posted was a photocopy. On October 22, 2025, at 12:06 p.m., LALD-A stated they were not aware the original license needed to be posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		

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0 650	Continued From page 12	0 650		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain record of competency evaluations for one of two 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	0 650		

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0 650	Continued From page 13 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: ULP-C was hired November 1, 2024, to provide assisted living services. On October 21, 2025, from 7:39 a.m., to 8:21 a.m., the surveyor observed ULP-C provide dressing, grooming, and medication administration services to R2 and R3. ULP-C's employee record contained a training transcript for an online training platform titled EduCare. The transcript lacked documentation competency evaluation was completed by a registered nurse (RN) for the following topics: - care and use of hearing aids; - medication, exercise, and treatment reminders; - understanding appropriate boundaries between staff and residents and the resident's family; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - administering medications or treatments as required; and - other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On October 21, 2025, at 11:39 a.m., licensed assisted living director (LALD)-A stated ULP-C received their training from a nurse that was previously employed by the licensee. LALD-A stated the nurse had passed away last month and many of the documents they were working on had been misplaced.	0 650		

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0 650	Continued From page 14 On October 21, 2025, at 1:03 p.m., ULP-C stated they had received in person training on medication administration and diabetes management from a previous nurse. ULP-C stated they did not recall receiving training on hearing aids. ULP-C stated they thought they received training on professional boundaries in the form of a meeting, and they also recalled receiving training on vital signs. The licensee's Personnel Records policy dated February 17, 2022, indicated the following: "At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements - Evidence of current professional licensure, registration or certification - Results of background studies - Records of annual training and infection control training - Documentation of orientation - Documentation of supervision, as applicable - Performance reviews - Competency evaluations - Signed job description - Documentation of annual performance reviews identifying areas of improvement needed and training needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 660		

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0 660	Continued From page 15 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), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of three 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 include: The licensee's TB risk assessment dated	0 660		

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0 660	Continued From page 16 February 2, 2025, indicated the facility was a low risk. ULP-C was hired November 1, 2024, to provide assisted living services. ULP-C's employee record contained documentation of negative results from a QuantiFERON TB gold blood test dated September 9, 2024. ULP-C's record lacked documentation of TB symptom screening. On October 23, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated they had not been responsible for the TB screening of staff, and did not complete a TB screening for ULP-C. CNS-B stated LALD-A would typically complete those tasks. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening/Prevention policy dated February 17, 2022, indicated a baseline TB screening at the time of hire is required for all health care workers in Minnesota. Baseline TB screening consists of three components: (1) assessing for current symptoms of active TB disease, and (2)	0 660		

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0 660	Continued From page 17 assessing TB history and 3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 700		

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0 700	Continued From page 18 The findings include: On October 21, 2025, while observing unlicensed personnel (ULP)-C complete medication administration, the surveyor observed ULP-C leave the licensee's laptop containing the electronic medication administration record (EMAR) unlocked and unattended from 7:58 a.m., to 8:01 a.m., and again from 8:17 a.m., to 8:21 a.m. The licensee's EMAR was in the main dining area on the upper floor of the facility, which served as the main dining area for residents and was located near the front entrance of the facility. On October 23, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to secure the EMAR. The licensee's Resident Confidentiality policy dated February 17, 2022, indicated all resident information, including but not limited to personal, financial and medical data, will be kept confidential and released only to authorized persons. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
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,	0 790		

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0 790	Continued From page 19 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 and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, 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 the potential to affect a large portion or all of the residents). The findings include: On October 21, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A. The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed. The fire extinguishers had a manufacture date of 2023 stamped on the bottom. LALD-A confirmed that the fire extinguishers were replaced with appropriately sized fire extinguishers after the last survey and have not been services since they were installed.	0 790		

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0 790	Continued From page 20 Documentation is required to demonstrate fire extinguishers have been annually replaced with a new extinguisher or serviced annually by a certified technician. TIME PERIOD FOR CORRECTION: Seven (7) 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 and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, 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 pattern scope (when more than a limited number of residents are affected,	0 800		

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0 800	Continued From page 21 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: On October 21, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. In the lower-level bathroom, there was water damage to the ceiling. LALD-A stated that they had previously repaired the water damaged ceiling. LALD-A stated that they would make the repairs to the water damaged ceiling. The windows in unoccupied resident room 5 had been altered by removing the originally equipped operating hardware that was replaced with two butt style hinges. When LALD-A opened the right-hand window to verify measurements of the emergency rescue and escape opening, the top hinge broke, and the window was hanging from the bottom hinge only. 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	0 810		

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0 810	Continued From page 22 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 810		

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0 810	Continued From page 23 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: On October 21, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated February 17, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the FSEP. The licensee failed to provide training to employees on the FSEP upon hire and at least	0 810		

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0 810	Continued From page 24 twice per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for staff on the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a	01440		

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	34357	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING BROOKDA	3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443

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01440	Continued From page 25 delegated task within 30 days of providing services for one of two 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 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-C was hired November 1, 2024, to provide assisted living services. On October 21, 2025, from 7:39 a.m., to 8:21 a.m., the surveyor observed ULP-C provide dressing, grooming, and medication administration services to R2 and R3. ULP-C's employee record lacked evidence of a 30-day supervision. On October 23, 2025, at 11:07 a.m., clinical nurse supervisor (CNS)-B stated they did not know if 30-day supervisions were being completed. CNS-B stated, "I remember a supervisory form, but I don't remember the 30-day part. A lot of this stuff [LALD-A] does." The licensee's Supervision: Unlicensed Staff policy, dated February 17, 2022, indicated supervision of home health aides performing medication or treatment administration shall be provided by the RN, and include observation of the staff administering the medication or	01440		

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01440	Continued From page 26 treatment and interacting with the resident. Additionally, direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 27 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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 observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of	01470		

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01470	Continued From page 28 three employees (clinical nurse supervisor (CNS)-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) 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: CNS-B was hired November 4, 2024, to provide clinical oversite and assisted living services. CNS-B's employee record lacked the following required orientation topics: - Overview of Assisted Living statutes; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license, and; - Principles of person-centered planning/service delivery. On October 22, 2025, at 12:18 p.m., licensed assisted living director (LALD)-A stated when a new nurse is hired, they assign EduCare trainings, and the nurse is expected to complete the trainings within a certain amount of time. The licensee's Staff Orientation and Education	01470		

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01470	Continued From page 29 policy dated February 17, 2022, indicated all staff providing assisted living services will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 b. Review of the employee's job description and responsibilities c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that ay act that constitutes maltreatment is prohibited f. The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff h. Grievance Policy/Process, including reports to the Office of Health Facility Complaints i. Consumer advocacy services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01530	Continued From page 30	01530		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the 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		

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01530	Continued From page 31 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 complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for three of three employees (clinical nurse supervisor (CNS)-B, (unlicensed personnel) ULP-C, and ULP-D). 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: CNS-B CNS-B was hired November 4, 2024, to provide clinical oversite and assisted living services. ULP-C ULP-C was hired November 1, 2024, to provide assisted living services. On October 21, 2025, from 7:39 a.m., to 8:21 a.m., the surveyor observed ULP-C provide dressing, grooming, and medication administration services to R2 and R3.	01530		

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01530	Continued From page 32 ULP-D ULP-D was hired October 7, 2024, to provide assisted living services. CNS-B, ULP-C, and ULP-D's employee records lacked documentation of completion of mental health and de-escalation training. On October 23, 2025, at 11:08 a.m., CNS-B stated they were not aware of the new requirements for mental health training. The licensee's policies did not address the new statutory requirement to provide mental illness and de-escalation training. 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	01640		

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01640	Continued From page 33 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 develop a written service plan which included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of three residents (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 August 26, 2025, to receive assisted living services. R2's primary diagnosis was diabetes. On October 21, 2025, at 7:39 a.m. to 7:48 a.m., the surveyor observed R2 recieve morning medication and treaments from ULP-C. R2's record contained a blank document titled	01640		

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01640	Continued From page 34 Exhibit 2: Service Plan Services. The document was built into the contract of R2 which had a signature date of August 26, 2025. R2's record lacked any additional service plan documentation. On October 23, 2025, at 11:22 a.m., licensed assisted living director (LALD)-A stated they were not aware R2's service plan had not been completed. The licensee's Service Plan policy dated February 17, 2022, indicated beginning with the date assisted living services are first provided, a service plan would be developed for the resident based on an agreement with the resident or responsible party and on the assessed needs identified in the comprehensive assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all	01880		

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01880	Continued From page 35 residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 20, 2025, at 11:17 a.m., the surveyor observed a refrigerator located in the common area of the licensee's basement. The refrigerator was unsecured and had no locking mechanism attached. Inside of the refrigerator the surveyor observed the following refrigerated medications: - a box of Wegovy 0.5mg/0.5ml injections belonging to R4; - a box of Wegovy 1mg/0.5ml injections belonging to R4; - a box of Insulin aspart flex pens 100units/ml belonging to R2; - two insulin aspart flex pens belonging to R2, and; - a Lantus insulin flex pen belonging to R2. On October 21, 2025, at 8:21 a.m., after the completion of the morning medication pass, the surveyor observed an unlocked and unsecured medication cabinet in the basement of the facility. The cabinet was located centrally in a common area of the basement and consisted of two doors facing one another and had a keyed hasp lock mounted between the doors to secure the doors together. The surveyor observed the hasp lock in the unlocked position which left the medication	01880		

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01880	Continued From page 36 cabinet unsecured, and accessible to unauthorized personnel. On October 21, 2025, at 1:56 p.m., the surveyor observed the licensee's medication cabinet in the basement of the facility was still unlocked an unsecured. On October 22, 2025, at 12:11 p.m., licensed assisted living director (LALD)-A stated staff were trained to ensure the cabinet was secured at all times. On October 22, 2025, at 12:54 p.m., the surveyor again observed the unlocked and unsecured medication cabinet in the basement of the facility. On October 23, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated the hasp lock mounted to the medication cabinet was broken and in need of replacement. CNS-B stated LALD-A had been notified a while ago and it was supposed to have been repaired. CNS-B stated they were surprised this had not yet been repaired yet. The licensee's Storage/Control of Medications policy dated February 17, 2022, indicated when the licensee is providing medication storage outside the resident's private living space, all prescription drugs will be securely locked in a substantially constructed compartments according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 37	01890		
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 ensure medications were maintained bearing the original prescription label with legible information and failed to ensure time sensitive medications were labeled with the date opened. 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 October 20, 2025, at 11:26 a.m., during a tour of the facility, the surveyor observed an unsecured medication refrigerator containing the following: - two undated insulin aspart pens belonging to R2; and - one undated Lantus insulin pen belonging to R2. On October 22, 2025, at 12:11 p.m., licensed	01890		

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ULTIMATE CARE ASSISTED LIVING BROOKDA	3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443

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01890	Continued From page 38 assisted living director (LALD)-A stated there was a policy in place that directed staff to label time sensitive medications when opened. On October 22, 2025, at 12:22 p.m., during an audit of the licensee's basement medication storage cabinet the surveyor observed the following: - a clear plastic sandwich bag taped to a medication card containing fludrocortisone tablets 0.1mg. Inside of the clear plastic sandwich bag were nine tablets which appeared to be the same medications in the card; and - an unlabeled and undated Trelegy Ellipta inhaler. On October 23, 2025, at 11:16 a.m., when asked about their expectations of labeling time sensitive medications, clinical nurse supervisor (CNS)-B stated, "are you talking about labeling each and every pen? Never heard of it. We go through all of those pens in less than 28 days." Additionally, CNS-B stated they were unaware Trelegy Ellipta needed to be labeled upon opening. The manufacturer's instructions for insulin aspart FlexPen indicated an in-use and opened pen should be stored for only 28 days refrigerated or room temperature. The manufacturer's instruction for Lantus indicated after opening, the medication should be stored at room temperature and should be disposed of after 28 days. The manufacturer's label printed on the back of the unlabeled and undated Trelegy Ellipta inhaler indicated the medication should be discarded six weeks after opening the tray or when the counter reads "0".	01890		

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	34357	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING BROOKDA	3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 39 The licensee's Storage/Control of Medications policy dated February 17, 2022, indicated when the licensee is providing medication storage outside the resident's private living space, all prescription drugs will be securely locked in a substantially constructed compartments according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced	01910		

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	34357	A. BUILDING: _____ B. WING _____	10/23/2025

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ULTIMATE CARE ASSISTED LIVING BROOKDA	3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443

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01910	Continued From page 40 by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the date of disposition and names of staff and other individuals involved in the disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 discharged from the licensee on November 25, 2024. R1's records lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On October 22, 2025, at 12:05 p.m., licensed assisted living director (LALD)-A stated the licensee did not have documentation of a medication disposition. LALD-A stated they believed the record may have been lost during record thinning. On October 23, 2025, at 11:05 a.m., when asked	01910		

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ULTIMATE CARE ASSISTED LIVING BROOKDA	3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443

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01910	Continued From page 41 about their process utilized when completing a medication disposition for discharged residents, clinical nurse supervisor (CNS)-B asked for clarification on the definition of the word "disposition". CNS-B then stated they were not familiar with the form or process. The licensee's Disposition and Disposal of Medications policy dated February 17, 2022, indicated upon disposition, the licensee will document the following information in the clinical record: - name, strength and prescription number of medication, as applicable; - quantity; - method of disposition or to whom the medications were given; - date of disposition; - name(s)/signature(s) of staff or other individuals involved in disposition; and - if applicable, to whom the medications were given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

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ULTIMATE CARE ASSISTED LIVING BROOKDA	3609 78TH AVENUE NORTH BROOKLYN PARK, MN 55443

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02310	Continued From page 42 Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of two residents (R4) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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 October 20, 2025, at 10:31 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated bed rails were assessed on an annual basis. On October 20, 2025, at 11:01 a.m., during a tour of the facility, the surveyor observed bilateral upper bed rails on R4's hospital bed. The hospital bed had no bed rails mounted to the lower half of the bed. The upper bed rails were in the upright (raised) position. R4 was admitted September 17, 2019, and began receiving assisted living services on August 1, 2021. R4's diagnosis included cerebral infarction, anxiety disorder, chronic kidney disease, chronic venous hypertension, difficulty in walking, and essential hypertension. R4's service plan dated May 1, 2024, indicated R4 received assisted living services including	02310		

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02310	Continued From page 43 bathing, oral cares, assistance with activities, activities with transfers, range of motion, meal preparation, partial assist with feeding, toileting, laundry, and medication management and administration. On October 22, 2025, at 1:23 p.m., licensed assisted living director (LALD)-A stated the licensee had no documentation of a bed rail assessment having been completed for R4. The licensee's Side Rail Use policy dated February 17, 2022, indicated the need for side rails will be reassessed and documented as needed but not less than every 90-days. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls.	02310		

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02310	Continued From page 44 This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 45 review, the licensee failed to ensure one of two unlicensed personnel (unlicensed personnel (ULP)-C) followed appropriate medication administration procedures. 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-C was hired November 1, 2024, to provide assisted living services. On October 21, 2025, at 7:49 a.m., the surveyor observed ULP-C go into the basement medication cabinet and retrieve R3's morning medications which were set previously in a Medi planner. ULP-C dumped the medications out of the Medi planner into a medication cup and began walking to R3's room for administration without first verifying medications against a medication administration record (MAR). The surveyor then intervened and asked if the medications were verified prior to administration. ULP-C stated when they log into the licensee's MAR in the morning they complete checks. At 7:52 a.m., the surveyor asked ULP-C to verify medications against the MAR. On October 21, 2025, at 8:01 a.m., the surveyor observed ULP-C go into the basement medication cabinet and retrieve R2's morning medications which were set previously in a Medi	02320		

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02320	Continued From page 46 planner. ULP-C dumped the medications out of the Medi planner into a medication cup and began walking to R3's room for administration without first verifying medications against a MAR. The surveyor again intervened and requested ULP-C verify R2's morning medications prior to administration. On October 21, 2025, at 8:34 a.m., ULP-C stated they were trained in medication administration by the previous nurse, and were trained to complete medication checks prior to administration. On October 23, 2025, at 11:13 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to and should be checking medications against the MAR prior to administration. The licensee's Staff Competency policy dated February 17, 2022, indicated staff must be trained and competency tested on administering medications or treatments as required. The licensee's Medications Administration policy dated February 17, 2022, indicated all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to the following: - purpose; - dosage; - route; - frequency; - instructions related to the medicaiton and specific, as appropriate; - side effects, and; - resident allergies to medications. No further information was provided.	02320		

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02320	Continued From page 47 TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

ULTIMATE CARE ASSISTED LIVING
3609 78TH AVENUE NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34357

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

Inspection Info

Report Number: F1051251147
Inspection Type: Full - Single
Date: 10/20/2025 Time: 11:30:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
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:
AT THE TIME OF INSPECTION, THERE IS NO CERTIFIED FOOD PROTECTION MANAGER. THE MANAGER, ALFRED, STATED THAT A STAFF IS SIGNED UP FOR A FOOD SAFETY TRAINING CLASS. ONCE THE STAFF HAS COMPLETED AND PASSED THE COURSE EXAM, HAVE THEM SUBMIT THEIR RESULTS TO MDH'S ONLINE APPLICATION. LINK TO APPLY WILL BE PROVIDED WITH THE REPORT VIA EMAIL.
Comply By: 4/20/2026 Originally Issued On: 10/20/2025

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, ZACHARY MORTH.

DISCUSSED THE FOLLOWING WITH THE MANAGER, ALFRED:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS
CERTIFIED FOOD PROTECTION MANAGER

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 St Cloud District Office inspection report number F1051251147 from 10/20/2025

Alfred
Manager

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

ULTIMATE CARE ASSISTED LIVING
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1051251147
Inspection Type: Full
Date: 10/20/2025
Time: 11:30:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No