



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 20, 2026

Licensee
Safecare Homes Inc.
763 County Road B2 West
Roseville, MN 55113

RE: Project Number(s) SL36604016

Dear Licensee:

On April 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 January 14, 2026. 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,

A handwritten signature in black ink that reads 'Stephanie Jones de Palma'.

Stephanie Jones de Palma

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Health Regulation Division
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320
Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 9, 2026

Licensee

Safecare Homes Inc.

763 County Road B2 West

Roseville, MN 55113

RE: Project Number(s) SL36604016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 14, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

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

pursuant to this :

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. 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,



Renee Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER SAFECARE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 763 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113		
(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: SL36604016-0 On January 12, 2026, through January 14, 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, all of whom were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
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	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480			

Minnesota Department of Health

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0 480	Continued From page 2 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 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 January 12, 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			

Minnesota Department of Health

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0 660	Continued From page 3	0 660			
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 observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB screening by completion of a two-step tuberculin skin test (TST), TB blood test, or a documented positive TB test with the required follow up chest x-ray for two of three employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 660			

Minnesota Department of Health

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0 660	Continued From page 4 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment, dated December 12, 2025, indicated the facility was at a low risk for TB transmission. ULP-B and ULP-C were hired April 21, 2025, and August 15, 2024, respectively, to provide direct care for residents of the facility. On January 13, 2026, from 8:00 a.m., to 2:00 p.m., during the survey, the surveyor observed ULP-B provide; meal preparation, housekeeping, and medication administration for the licensee's residents. ULP-B and ULP-C's records both included a negative chest x-ray dated April 16, 2025, and July 13, 2024, respectively. ULP-B and ULP-C's record each lacked documentation of either a previous positive TB test or documentation of completion of TB treatment, correlated to the chest x-rays. On January 13, 2026, at 12:10 p.m., owner/licensed assisted living director (O/LALD)-A stated he was not aware a previous positive TB test was required to be kept in an employee's file along with the chest x-ray, to meet the requirement of baseline TB screening. The licensee's Tuberculosis Screening/Prevention policy, dated August 1, 2021, indicated "employees with a verbal, but	0 660			

Minnesota Department of Health

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0 660	Continued From page 5 undocumented, history of a previous positive TST or [blood test] will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use." The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 16, 2019, recommended all health care professionals complete a TB screening including a symptom evaluation and an IGRA or TST. Health care workers with written documentation of a previous positive TST or IGRA should have documented in their record: test results, assessment for current TB symptoms and a related chest x-ray. The Minnesota Department of Health (MDH) Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH, updated June 6, 2024, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680	Continued From page 6	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all required content as defined in Centers for Medicare and Medicaid Services (CMS) Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

Minnesota Department of Health

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0 680	Continued From page 7 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: The licensee's EP plan, reviewed January 10, 2026, lacked evidence of the following required content: - documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. On January 12, 2025, at 1:30 p.m., owner/licensed assisted living director (O/LALD)-A stated they held fire drills monthly and the additional exercises were done at that time, but they were not documenting them. O/LALD-A stated they should have been documenting them separately. The licensee's undated 4.01 Training, Exercises, and Testing policy indicated the licensee would conduct an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. The policy indicated the exercised would be documented. No further information was provided.	0 680			

Minnesota Department of Health

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0 680	Continued From page 8	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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 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 January 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			

Minnesota Department of Health

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0 790	Continued From page 9	0 790			
0 790 SS=D	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 and interview, 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 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 January 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 790			

Minnesota Department of Health

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0 790	Continued From page 10	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, 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 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	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER SAFECARE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 763 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113		
(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
0 800	Continued From page 11 January 12, 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=I	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 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	0 810			

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01060	Continued From page 13 another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.	01060			

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01060	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the resident or their representative a written notice after an emergency relocation 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 the potential to affect a large portion or all of the residents). The findings include: R2's service plan, dated December 12, 2025, indicated R2 received services including assistance with medication administration. R2's medication administration record for September 2025, indicated R2 was hospitalized from September 18, 2025, to September 26, 2025. R2's record lacked documentation a notice was provided to the resident, and the Office of Ombudsman for Long-Term Care when the resident had not returned to the facility within four days, with the following required content: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060			

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01060	Continued From page 15 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On January 13, 2026, at 11:50 a.m., owner/licensed assisted living director (O/LALD)-A stated R2 was hospitalized from September 18, 2025, to September 26, 2025, and an emergency relocation notification had not been provided to the resident, or the Office of Ombudsman for Long-Term Care. Registered nurse (RN)-D and O/LALD-A stated they were not aware of the requirement. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated in the event of an emergency relocation, the licensee would provide written notice to the resident or resident representative, as soon as possible. The policy further indicated the Office of Ombudsman for Long-Term Care would be notified within four days following the emergency relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

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01470	Continued From page 16	01470			
01470 SS=D	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 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	01470			

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01470	Continued From page 17 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 interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of three employees (registered nurse (RN)-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 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:	01470			

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01470	Continued From page 18 RN-D was hired January 23, 2024, to provide supervision and direct care services for the licensee's residents. RN-D's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: - an overview of the appropriate Assisted Living statutes 144G and rules; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - review of types of Assisted Living services the employee will provide and provider's scope of license. On January 13, 2026, at 11:20 a.m., owner/licensed assisted living director (O/LALD)-A stated he had assigned the educations to staff, but it looked like they were not completing them. O/LALD-A further stated "I'll need to make sure" the educations assigned were being completed. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated orientation would include all the required topics and documented in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			

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01500	Continued From page 19	01500			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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01500	Continued From page 20 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C, registered nurse (RN)-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 the potential to affect a large portion or all of the residents). The findings include:	01500			

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01500	Continued From page 21 ULP-C ULP-C was hired August 15, 2024, to provide direct care services to residents. ULP-C's employee record lacked documentation the employee had successfully completed at least eight hours of annual training for every 12 months of employment as required under 144G.63, Subd.5, to include the following: -training on reporting of maltreatment of vulnerable adults under section 626.557; -assisted living bill of rights; -infection control techniques; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of providers policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. RN-D RN-D was hired January 23, 2024, to provide supervision and direct care services for the licensee's residents. RN-D's employee record lacked documentation the employee had successfully completed at least eight hours of annual training for every 12 months of employment as required under 144G.63, Subd.5, to include the following: - assisted living bill of rights On January 13, 2026, at 11:20 a.m., owner/licensed assisted living director (O/LALD)-A stated he had assigned the educations to staff, but it looked like they were	01500			

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01500	Continued From page 22 not completing them. O/LALD-A further stated I'll need to make sure" the educations assigned are being completed. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated annual education would include all the required topics and documented in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of 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	01530			

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01530	Continued From page 23 this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff completed the required amount of dementia, mental illness, and de-escalation training, in the required time frame for three of three employees (registered nurse (RN)-D, unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01530			

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01530	Continued From page 24 RN-D RN-D was hired January 23, 2024, to provide supervision and direct care services for the licensee's residents. RN-D's employee record lacked documentation they had completed the required 8 hours of initial dementia care training within 120 hours of working. ULP-B and ULP-C ULP-B and ULP-C were hired April 21, 2025, and August 15, 2024, respectively, to provide direct care the licensee's residents. ULP-B and ULP-C's employee records lacked documentation they had completed the required 8 hours of initial dementia care training and 2 hours of mental illness and de-escalation training within 120 hours of working. ULP-C's record further lacked documentation they had completed the required 2 hours of annual dementia training. On January 13, 2026, during continuous observation from 8:00 a.m. to 8:30 a.m., the surveyor observed ULP-B assisting the licensee's residents with medication administration. On January 13, 2026, at 11:20 a.m., owner/licensed assisted living director (O/LALD)-A stated he did not realize he wasn't assigning the correct number of hours for dementia care upon orientation, and it looked like staff were not completing the educations he was assigning to them. O/LALD-A further stated "I'll need to make sure" the educations assigned were being completed on time.	01530			

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01530	Continued From page 25 The licensee's Dementia Education policy dated August 1, 2021, indicated all staff of licensee would complete dementia training in accordance with Minnesota Statutes, section 144G.64, and training would occur within the required timeframes based on staff roles and would continue annually. The policy lacked an indication employees would receive education on mental illness and de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse:	01620			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 26 (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure the registered nurse (RN) completed ongoing comprehensive reassessments using the uniform assessment tool at an interval not to exceed 90 days 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
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01620	Continued From page 27 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's service plan, dated December 12, 2025, indicated R2 received services including assistance with medication administration. On January 13, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B assisting R2 with medication administration. R2's record included a comprehensive nursing assessment, dated September 27, 2025, and a reassessment dated December 31, 2025, greater than 90 days (95 days) after the previous assessment. On January 13, 2026, at 11:45 a.m., RN-D stated the assessment had been completed late. RN-D further stated they had been "under the weather" and having trouble with their technology at the time the assessment was due. The licensee 6.01 Assessments, Review and Monitoring policy, dated May 30, 2023, indicated, "resident monitoring and review must be conducted as needed based on changed in the needs of the resident and cannot exceed 90 calendar days from the date of the last review." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
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01620	Continued From page 28 (21) days	01620			
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 observation, interview, and record review, the licensee failed to ensure a current written service plan was revised and included a signature or other authentication by the resident, or their representative, documenting agreement on the services to be provided for one of one residents (R2). This practice resulted in a level two violation (a	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
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01640	Continued From page 29 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's signed Service Plan dated April 18, 2025, indicated R2 received services including assistance with housekeeping, laundry, behavior management, grooming and bathing reminders. R2's current service plan dated December 30, 2025, indicated R2 received the following additional services: medication administration. R2's service plan lacked a signature to document agreement with the added service. On January 13, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B assisting R2 with medication administration. On January 13, 2026, at 12:10 p.m., owner/licensed assisted living director (O/LALD)-A stated R2 began receiving assistance with medication administration September 26, 2025, and a new service plan should have been signed when it was updated. O/LALD-A stated it must have been missed. The licensee's Service Plan policy dated August 1, 2021, indicated "the initial service plan and any revisions are signed by a representative from [Licensee] and the resident or resident's representative, indicating agreement with the services to be provided."	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
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01640	Continued From page 30 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication name, quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1) with record reviewed.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER SAFECARE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 763 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113		
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01910	Continued From page 31 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: R1 was admitted to the licensee on March 21, 2025, and discharged on August 23, 2025. R1's Service Plan, dated August 1, 2025, indicated R1 received services including assistance with medication administration. R1's record lacked documentation of R1's disposition of medications upon termination of the service plan which included the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On January 12, 2026, at 12:00 p.m., owner/licensed assisted living director (O/LALD)-A stated they did not have a disposition record for R1. O/LALD-A further stated they had not disposed of R1's medications at the time R1 discharged and they should have. The licensee's Disposition and Disposal of Medications policy, dated August 1, 2021, indicated medications managed by the licensee would be given to the resident or responsible	01910			

Minnesota Department of Health

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01910	Continued From page 32 party when the resident's service plan ended or upon discharge, and a note would be placed in the clinical record. The policy further indicated a licensed nurse would destroy any medications remaining in storage after the termination of the medication management program for a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



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

Page: 1

Establishment Info

SAFECARE HOMES INC
763 County Road B2 West
Roseville, MN 55113
Ramsey County
Parcel:

Phone:

License Info

License: HFID 36604

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

Inspection Info

Report Number: F1025261011
Inspection Type: Full - Single
Date: 1/12/2026 Time: 1:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 *Priority Level: Priority 1 CFP#: 22*

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: Food and ambient temperatures in refrigerator above 41 deg F. Maintain at or below 41 deg F. Refrigerator turned down during inspection. Monitor temperatures using the available food thermometer.

Comply By: 1/12/2026 Originally Issued On: 1/12/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: Provide a means for testing the internal temperature of the dishwasher.

Comply By: 1/16/2026 Originally Issued On: 1/12/2026

! 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: *Note: 150 deg F for NSF 184 dishwashers

Sanitize cycle not selected for the dishwasher. Sanitize cycle selected during inspection and cycle restarted. COS. Ensure the dish machine is set to sanitize when washing food contact surfaces.

Comply By: Complied On Site Originally Issued On: 1/12/2026

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

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

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: Clean high-touch areas on the cabinetry, and repair and repaint areas where paint has worn to the wood.

Discussed adding smooth, durable, easily cleanable door hardware to keep high-touch areas clean to sight and touch.

Comply By: 2/27/2026 Originally Issued On: 1/12/2026

Food & Beverage General Comment

Dishwasher operation: if the dishwasher cycle is interrupted, restart the cycle at the beginning to complete sanitization.

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 F1025261011 from 1/12/2026



Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
SAFECARE HOMES INC	Report Number: F1025261011
Roseville	Inspection Type: Full
County/Group: Ramsey County	Date: 1/12/2026
	Time: 1:00 PM

Food Temperature: **Product/Item/Unit:** Sauce, TCS; **Temperature Process:** Cold holding
Location: Refrigerator at 45 Degrees F.
Comment:
Violation Issued?: Yes

Minnesota (MDH) Version EH Manager; RPT: F1025261011			Food Establishment Inspection Report			Page 1 of 1			
 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164			No. of Risk Factor/Intervention/Violations		2	Date: 1/12/2026			
			No. of Repeat Risk Factor/Intervention/Violations			Time: 1:00 PM			
			Score (optional)			Dur: min			
Establishment: SAFECARE HOMES INC		Address: 763 County Road B2 West		City/State: Roseville, MN		Zip: 55113		Phone:	
License/Permit #: HFID 36604		Permit Holder:		Purpose of Inspection: Full		Est. Type:		Risk Category:	
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS									
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation				
Compliance Status			COS	R	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	IN	Certified Food Protection Manager			19	N/O	Proper reheating procedures for hot holding		
Employee Health					20	N/O	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	N/O	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	OUT	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	IN	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	IN	Hands clean and properly washed			26	N/A	Pasteurized foods used; prohibited foods not offered		
9	IN	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	IN	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	IN	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	IN	Food separated and protected							
16	OUT	Food-contact surfaces; cleaned & sanitized	X						
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							
GOOD RETAIL PRACTICES									
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" or OUT in box if numbered item is not in compliance			Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation						
			COS	R				COS	R
Safe Food and Water					Proper Use of Utensils				
30	N/A	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/O	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48	X	Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55	X	Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
Inspector (signature) 					58		Compliance with licensing and plan review		
					Follow-up: Follow-up Date:				

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36604016-0	Date: January 12, 2026
Facility Name: SAFECARE HOMES INC	
Facility Address: 763 COUNTY ROAD B2 WEST, ROSEVILLE, MN 55113	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

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. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: In occupied resident room four, one burnt cigarette with ashes were disposed of on the windowsill; and one burnt cigarette had been discarded on the floor.

3. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments:

- The garage back door was labeled as an emergency exit on the evacuation floor plan dated March 2022. A clear continuous egress path from this door to the public right of way was not maintained free of snow.
- In occupied resident sleeping room one, the headboard attached to the bed frame obstructed the egress window.
- In occupied resident sleeping room four, access to the egress window was obstructed by the storage of personal items in front of the window.

4. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

Comments:

- In the basement, between the recreation room and utility area, a cover was not installed on one light switch and there was an open electrical outlet box.

- In occupied resident room 4, there was an open electrical outlet box for a hard wired smoke alarm on the ceiling. Licensed assisted living director (LALD)-A stated during the tour that when the interconnected smoke alarm system was installed, a new ceiling outlet had been added, and the old outlet was no longer used.

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

Comments:

- In the main floor living room office space, two power strips were daisy chained together and plugged into a multi outlet plug adapter.

- In occupied resident room three, two powers strips were daisy chained together to supply power to personal electronics.

6. Single or multiple-station smoke alarms shall be maintained. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10.2]

Comments: The hardwired smoke alarm installed in occupied resident sleeping room four was “chirping” and the back-up battery was missing.

7. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: A carbon monoxide detector was not installed within ten feet of basement bedroom four. The building had a gas clothes dryer and attached garage.

8. Occupancy separations shall be provided in Group R occupancies. These separations shall be constructed and maintained in accordance with the Building Code. Existing wood lathe and plaster in good condition or ½ inch gypsum wall board is acceptable where one-hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

Comments: There was a hole on the garage side of the common wall that separated the dwelling unit from the attached garage. The hole shall be sealed to prevent the passage of smoke or fire from one side of the wall to the other.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: In the basement, the distance between the floor and bottom of the portable fire extinguisher measured sixty-two inches. The top of the fire extinguisher shall be no more than sixty inches from the floor.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

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:

- On the back side of the building exterior there was a piece of metal strapping with an exposed nail in the designated smoking area for residents.
- The cover was missing on the exterior light at the main entrance door.
- The base trim was water damaged in the basement resident bathroom.
- The window blinds were in disrepair in occupied resident room 3.
- One side of the bifold closet was off the track in occupied resident room 3.
- The doorknob was loose and the door surface damaged around the knob in occupied resident room 4.
- The cover for the light was missing in occupied resident room 4.
- There were several holes in the wall and ceiling in occupied resident room 4.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

-
1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The emergency evacuation floor plan was not posted in the basement.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: Resident sleeping rooms were not accurately identified. The numbers posted at the resident room doors did not match the emergency evacuation floor plan, dated March 2022. The number identifiers installed on or at the resident sleeping room doors need to correspond accurately with the floor plan to

provide efficient communication for exiting in the event of a fire or similar emergency. Additionally, the main floor bathroom was inaccurately labeled with the same abbreviation as a bedroom.

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

Comments:

- The licensee failed to develop the fire safety and evacuation plan (FSEP), dated July 1, 2025, with site 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 FSEP inaccurately referenced pull fire alarms and elevators.*
- The FSEP inappropriately directs employees to evacuate residents to a fire safe zone or defend in place in a building without life safety systems or fire resistant construction.*
- The evacuation floor plan dated March 2022, inappropriately labeled the attached garage as an emergency exit. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard space.*

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that includes fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP resident instructions were limited to "follow staff instructions during an emergency".

5. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to develop the FSEP with site specific evacuation procedures.

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

Comments: The surveyor requested three employee FSEP training records for the past year. One employee FSEP training record dated May 1, 2025, was provided.

7. 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: The surveyor requested three resident fire safety and evacuation training records for the past year. Records were not provided for two residents.

8. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: Fifteen fire drill audit records were provided for the past year. All drills were completed during the day and night shifts. Licensed assisted living director (LALD)-A stated employee fire drills had been completed by combining shifts. Additionally, the simulated fire locations within the building were not recorded on any of the drill audits.