Electronically Delivered

October 10, 2025

Licensee
West Metro Care Services LLC
201 103rd Avenue Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL38120016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 3, 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 - 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 $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38120	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

(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: SL38120016-0 On September 2, 2025, through September 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; all of whom were receiving services under the Assisted Living Facility license. An immediate correction order was identified on September 3, 2025, issued for SL38120016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk for tag identification 0775. 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.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (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;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 2, 2025, for the specific Minnesota Food Code violations. The	0 480		

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0 480	Continued From page 3 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		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 485		

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0 485	Continued From page 4 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 2, 2025, at 10:00 a.m., licensed assisted living director (LALD)-C stated the licensee was familiar with current minimum assisted living requirements. The licensee's Resident Contract that is used by all residents indicated, "[Licensee] offers the meal plans as a supportive service described in the disclosure. You are not required to select a meal plan to live at [licensee]. The cost of your meal plan, should you select one, is included in your Monthly Base Fee. If medically required (per physician/dietician), [licensee] will provide specialized diets." The contract also went on to indicate, "[Licensee] will offer at least three nutritious meals daily with snacks available seven days per week, in accordance with the recommended dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables. Menus will be prepared at least one week in advance and made available to all residents. [Licensee] will encourage residents' involvement in menu planning. Meal substitutions will be of similar nutritional value if a resident refuses a food that is served Residents will be informed in advance of menu changes. Food will he prepared and served according to the Minnesota Food Code, Minnesota Rules. chapter 4626. [Licensee] will not require a residenl to	0 485		

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0 485	Continued From page 5 include and pay for meals in the resident contract." Resident assisted living contracts lacked an option for residents to opt out of payment for just one meal that residents would not want. On September 3, 2025, at 11:25 a.m., clinical nurse supervisor (CNS)-D stated, "I didn't know we needed to break it down." The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following 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	0 650		

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0 650	Continued From page 6 qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-F and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F ULP-F was hired February 26, 2023, to provide direct care and services to residents. ULP-G ULP-G was hired May 4, 2024, to provide direct cares and services to residents.	0 650		

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0 650	Continued From page 7 On September 3, 2025, at 6:50 a.m., surveyor observed ULP-F assist residents with morning cares. ULP-F and ULP-G's employee records lacked any annual performance review for the years of employment with the licensee. On September 3, 2025, at 11:38 a.m., clinical nurse supervisor (CNS)-D stated, "Sorry I don't have that, so it will be another tag." The licensee's Staff Annual Performance Appraisals policy, dated January 1, 2025, indicated, ""All employees shall receive a formal, written performance appraisal at least once every 12 months." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650		
0 775 SS=I	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 provide egress windows in compliance with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents.	0 775		

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0 775	Continued From page 8 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, 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 September 3, 2025, the surveyor toured the facility with unlicensed personnel (ULP)-E and clinical nurse supervisor (CNS)-D. During the tour, survey staff asked ULP-E to open the windows in the resident rooms for measurement. The noncompliant measurements were as follows: Resident room 1: The window measured 20 inches clear width, 30 inches clear height, and 600 square inches total open area. Resident room 2: The window measured 20 inches clear width, 30 inches clear height, and 600 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. TIME PERIOD FOR CORRECTION: Immediate	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790		

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0 790	Continued From page 9 (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 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) 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 September 3, 2025, the surveyor toured the facility with unlicensed personnel (ULP)-E and clinical nurse supervisor (CNS)-D. The portable fire extinguishers in the facility were mounted so that the top of the fire extinguisher was at 72 inches from the finished floor.	0 790		

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0 790	Continued From page 10 Portable fire extinguishers shall be permanently mounted in a conspicuous location at least four inches off the floor and no higher than five feet above the floor to the top of the extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=A	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 an isolated scope (when one or a limited number of residents are affected or	0 800		

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0 800	Continued From page 11 one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 3, 2025, the surveyor toured the facility with unlicensed personnel (ULP)-E and clinical nurse supervisor (CNS)-D. The following was observed. The patio door handle leading from the kitchen to the outside was missing the top screw and was hanging by the bottom screw and upside down. The closer for the front screen door was disconnected from the door frame. 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	0 810		

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WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

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0 810	Continued From page 12 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 and drills. This had the potential to directly affect all residents, staff, and visitors. 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:	0 810		

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0 810	Continued From page 13 On September 3, 2025, clinical nurse supervisor (CNS)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and P.A.S.S (Pull, Aim, Squeeze, and Sweep) but the plan was designed for a building with life safety systems such as sprinklers. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems. 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. CNS-D lacked resident training documentation on the FSEP and stated that residents receive verbal training on the facilities FSEP. DRILLS:	0 810		

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0 810	Continued From page 14 The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted quarterly. Drills shall be conducted twice per year per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one residents (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 910		

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0 910	Continued From page 15 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee had an active Assisted Living license dated February 2, 2025, through February 1, 2026. R2 R2 was admitted to the licensee and began receiving assisted living services on March 22, 2023. R2's record included a [Licensee] assisted living contract dated March 22, 2023. R2's written contract lacked the following required content: - the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. On September 3, 2025, at 11:30 a.m. clinical nurse supervisor (CNS)-D stated, "It's an old contract from when we started, everyone uses that contract, and I didn't know, things keep changing, so HFID number will be added in the contract." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		

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01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. 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.	01060		

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01060	Continued From page 17 (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative 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) 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 was admitted to the licensee and began receiving assisted living services on March 22, 2023. R2's signed Service Plan, dated March 22, 2023, indicated R2 received services including assistance with medication administration, grooming, housekeeping, laundry, linens, bathing, and dressing. On September 3, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-D provided surveyor with an email that CNS-D had sent to the ombudsman that read, "Good day, I want to notify your office that [R2] with diagnosis of COPD was taken to	01060		

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01060	Continued From page 18 the ER at Mercy Hospital and she's expected to be discharged home with supplemental oxygen. Thanks [CNS-D]" R2's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. On September 2, 2025, at 1:28 p.m., CNS-D stated, "I did not give [R2] a form, I don't give them to the residents, but I did send an email to the ombudsman." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	01370		

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01370	Continued From page 19 (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three unlicensed personnel ((ULP)-A and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01370		

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01370	Continued From page 20 found to be pervasive). The findings include: ULP-A ULP-A was hired on March 6, 2025, to provide direct care services to residents. ULP-G ULP-G was hired on May 4, 2024, to provide direct care services to residents. On September 2, 2025 at 11:58 surveyor observed ULP-A administer medications to R2. ULP-A and ULP-G's employee records lacked documentation of training and competency evaluations for ULP's providing assisted living services including: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - training on the prevention of falls; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 21 On September 3, 2025, at 11:38 a.m., clinical nurse supervisor (CNS)-D acknowledged the missing training and stated, "My training is horrible, maybe I was too excited, and I didn't click all the ones needed for them to do, that is my fault, and I take responsibility for it. I will go through and fix it." The licensee's Orientation Training Policy, dated August 1, 2021, indicated, All staff must complete orientation training within 90 days of working in the facility, orientation completion forms would be signed by the employee and supervisor, and records would be maintained in the personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

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01380	Continued From page 22 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three unlicensed personnel ((ULP)-A and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on March 6, 2025, to provide direct care services to residents. ULP-G ULP-G was hired on May 4, 2024, to provide direct care services to residents. On September 2, 2025 at 11:58 surveyor observed ULP-A administer medications to R2. ULP-A and ULP-G's employee records lacked the following training and competency evaluations:	01380		

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01380	Continued From page 23 - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On September 3, 2025, at 11:38 a.m., clinical nurse supervisor (CNS)-D acknowledged the missing training and stated, "My training is horrible, maybe I was too excited, and I didn't click all the ones needed for them to do, that is my fault, and I take responsibility for it. I will go through and fix it." The licensee's Orientation Training Policy, dated August 1, 2021, indicated, All staff must complete orientation training within 90 days of working in the facility, orientation completion forms would be signed by the employee and supervisor, and records would be maintained in the personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=E	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;	01470		

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01470	Continued From page 24 (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 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	01470		

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01470	Continued From page 25 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 staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of three unlicensed personnel ((ULP)-A and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on March 6, 2025, to provide direct care services to residents. ULP-G	01470		

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	38120	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

(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
01470	Continued From page 26 ULP-G was hired on May 4, 2024, to provide direct care services to residents. On September 2, 2025 at 11:58 surveyor observed ULP-A administer medications to R2. ULP-a and ULP-G's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - Overview of Assisted Living statutes; - Handing of resident complaints, reporting of complaints, where to report; -Reporting maltreatment of vulnerable adults or minors; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On September 3, 2025, at 11:38 a.m., clinical nurse supervisor (CNS)-D acknowledged the missing training and stated, "My training is horrible, maybe I was too excited, and I didn't click all the ones needed for them to do, that is my fault, and I take responsibility for it. I will go through and fix it." The licensee's Orientation Training Policy, dated August 1, 2021, indicated, All staff must complete orientation training within 90 days of working in the facility, orientation completion forms would be signed by the employee and supervisor, and records would be maintained in the personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38120	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

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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 topics related to	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38120	A. BUILDING: _____ B. WING _____	09/03/2025

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WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

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01530	Continued From page 28 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 license 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 (ULP-A, ULP-F, and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on March 6, 2025, to provide direct care services to residents. ULP-F ULP-F was hired February 26, 2023, to provide direct cares and services to residents. ULP-G ULP-G was hired on May 4, 2024, to provide direct care services to residents. On September 2, 2025 at 11:58 surveyor observed ULP-A administer medications to R2.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38120	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

(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
01530	Continued From page 29 ULP-A, ULP-F, and ULP-G's record lacked training on mental illness and de-escalation. On September 3, 2025, at 11:38 a.m., clinical nurse supervisor (CNS)-D acknowledged the missing training and stated, "I have to go do that, I will assign it for the others" The licensee's Mental Illness Training Policy, dated August 1, 2021, indicated, "All staff, including clinical and non-clinical personnel, must receive training on mental illness at hire and annually thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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,	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38120	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

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01910	Continued From page 30 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 the prescription number for the disposition for one of one discharged residents (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 was admitted to the licensee and began receiving services on July 31, 2024. R1 discharged on February 11, 2025. R1's record included a Medication Disposition-Resident form dated February 11, 2025. the disposition lacked the prescription numbers as applicable. On September 3, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-D stated, " I didn't know I needed to have that."	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38120	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST METRO CARE SERVICES LLC	201 103RD AVENUE NORTHWEST COON RAPIDS, MN 55448

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01910	Continued From page 31 The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated the licensee would document the prescription number of medication as applicable. 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

Establishment Info

WEST METRO CARE SERVICES LLC
201 103RD AVENUE NW
Coon Rapids, MN 55448
Anoka County
Parcel:

Phone:

License Info

License: HFID 38120

Risk:
License:
Expires on:
CFPM: ADEYEYE SAMUEL OGUNSINA
CFPM #: 8810; Exp: 6/2/2028

Inspection Info

Report Number: F1029251153
Inspection Type: Full - Single
Date: 9/2/2025 Time: 12:30:26 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG. VISITED MDH WEBSITE DURING INSPECTION AND DOWNLOADED AND PRINTED EMPLOYEE ILLNESS LOG. LOGGING, EXCLUSION, AND NOTIFICATION REQUIREMENTS REVIEWED.
Comply By: 9/2/2025 Originally Issued On: 9/2/2025

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: AREAS OF MILLWORK WITH MISSING FINISHES AND BREAKS IN LAMINATE WITH BOWED MDF UNDERNEATH NEAR SINK. MAINTAIN SANITARY AND PEST FREE. FINISHES AND MATERIALS SHALL BE MADE SMOOTH, DURABLE, NON-ABSORBENT, AND EASILY CLEANABLE IF SANITARY PEST FREE CONDITIONS CANNOT BE MAINTAINED.
Comply By: 9/2/2025 Originally Issued On: 9/2/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.19 *Priority Level: Priority 3 CFP#: 53*
MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.
COMMENT: BATHROOM DOOR OPEN. KEEP CLOSED WHEN NOT CLEANING OR MAINTAINING.
Comply By: 9/2/2025 Originally Issued On: 9/2/2025

Food & Beverage General Comment

Food and beverage inspection conducted as part of HRD nursing survey of assisted living facility. Establishment is residential in nature and only provides a same day food and beverage service. Whirlpool sanitizing dishwasher used to sanitize equipment and utensils. Identified issues reviewed with the operators throughout the inspection and with the nursing surveyor following the inspection.

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 F1029251153 from 9/2/2025

Trevor McPliment

ADEYEYE OGUNSINA
PERSON IN CHARGE

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

WEST METRO CARE SERVICES LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1029251153
Inspection Type: Full
Date: 9/2/2025
Time: 12:30:26 PM

New Record: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cooling
Location: REFRIGERATOR at 47 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 42 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: INTERNAL THERMOMETER**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

WEST METRO CARE SERVICES LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1029251153
Inspection Type: Full
Date: 9/2/2025
Time: 12:30:26 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: **Equal To** 183 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** QUATERNARY AMMONIUM**; Sanitizing Process:** Spray Bottle
Location: **Equal To** 400 PPM
Comment:
Violation Issued?: No