DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 22, 2025

Licensee
Great Health Care LLC
4501 Winchester Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL40727015

Dear Licensee:

On May 28, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on March 5, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 5, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 5, 2025, found not corrected at the time of the May 28, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
1530-Training In Dementia, Mental Illness, And De--144g.64 (a) (1-2)

The details of the violations noted at the time of this follow-up survey completed on May 28, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

IMPOSITION OF FINES:

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

in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

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

KKM

Electronically Delivered

April 14, 2025

Licensee
Great Health Care LLC
4501 Winchester Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL40727015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on March 5, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

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

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

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health 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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40727	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HEALTH CARE LLC	4501 WINCHESTER LANE BROOKLYN CENTER, MN 55429

(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 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: SL40727015-0 On March 3, 2025, through March 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one (1) resident; 1 receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to employ a licensed assisted living director (LALD) licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS). The deficient practice had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety, but had the potential have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 28, 2025, at 8:16 a.m., the Minnesota Board of Executives for Long-Term Services and Supports (BELTSS) website indicated owner/director (O/D)-A had a residency permit affiliated with another provider that had expired on September 7, 2024. On March 3, 2025, at 10:10 a.m., O/D-A stated she was the LALD for licensee, but she had not successfully completed her exams. On March 3, 2025, at 4:00 p.m., O/D-A provided surveyor a copy of email correspondence dated	0 110		

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0 110	Continued From page 2 January 8, 2024, through March 3, 2025, between O/D-A and BELTSS. The email correspondence indicated O/D-A was requesting testing dates and a new license. On March 3, 2025, at 4:00 p.m., O/D-A sent an email to surveyor that indicated mentor (M)-E's director license will be the one to hang on the wall because he was the active director for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 420		

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0 420	Continued From page 3 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a provisional assisted living facility license, effective April 29, 2024, with an expiration date of April 28, 2025. The licensee's Provisional Assisted Living Licensure Information and Application, section titled Official Verification of Owner or Authorized Agent, (page 17 and 18 of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.	0 420		

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0 420	Continued From page 4 - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing	0 420		

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0 420	Continued From page 5 the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page 18 was signed by O/D-A on November 19, 2023. As a result of this survey, the following orders were issued 0110, 0470, 0480, 0550, 0640, 0650, 0660, 0680, 0790, 0800, 0810, 0910, 0950, 0970, 1370, 1380, 1530, 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		

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0 470	Continued From page 6	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed a staffing plan to determine staffing levels to meet the needs of all residents and ensure the staffing plan was reviewed at a minimum of twice a year as required. This had the potential to affect all	0 470		

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0 470	Continued From page 7 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 finding include: The licensee held an assisted living facility license and was licensed for a census of 5 residents, with a current census of 1 resident. During the entrance conference on March 3, 2025, at 10:30 a.m., the surveyor requested a copy of the licensee's staffing plan from owner/director (O/D)-A. On March 4, 2025, at 1:06 p.m., O/D-A stated their consultant informed them the monthly schedule would suffice as their staffing plan. The licensee failed to provide a developed staffing plan to include the following: - includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility.	0 470		

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0 470	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480		

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0 480	Continued From page 9 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 480		

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	40727	A. BUILDING: _____ B. WING _____	03/05/2025

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0 480	Continued From page 10 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure to include required content. This had the potential to affect all residents receiving assisted living	0 550		

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0 550	Continued From page 11 services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 March 3, 2025, at 11:30 a.m., during the facility tour, the surveyor observed a Complaint Policy and Procedure posted in the common area of the facility. The posting lacked the following required information: -the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances; -the contact information for the Office of the Ombudsman for Long-Term Care; -the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; -information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC); and -a statement that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH). On March 3, 2025, at 11:30 a.m., owner/director (O/D)-A stated the required contact information was not included in the grievance posting. LALD-A stated they were unaware the required content was not included in the grievance posting.	0 550		

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0 550	Continued From page 12 The licensee's undated Complaint Policy and Procedure (posted) indicated each resident would receive written notice of the licensee's proves for receiving and resolving complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in the assisted living facility common areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 13 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 3, 2025, at 11:12 a.m., during a facility tour, the surveyor observed the facility lacked a posting of information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. On March 3, 2025, at 11:15 a.m., owner/director (O/D)-A stated they were unaware of the requirement to post contact information for MAARC. The licensee's MAARC Report Procedure policy (undated) read "If you have witnessed or know of a vulnerable adult who has been the victim of physical or mental abuse, neglect, financial exploitation, or unexplained injuries act now to file a complaint or report an incident. Complaints can be reported to the Minnesota Adult Abuse Reporting Center (MAARC) by calling (844) 880-1574 (toll free)." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records	0 650		

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0 650	Continued From page 14 (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 650		

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0 650	Continued From page 15 failure that has affected or has the potential to affect a large number or all the residents). The findings include: ULP-C ULP-C was hired October 21, 2024, and began providing assisted living services. On March 3, 2025, at 11:42 a.m., ULP-C was observed administering medication to R1. ULP-C's employee record included a Care Fundamentals Orientation Checklist dated October 7, 2024. The treatment and therapies section of the checklist (page 5) lacked a registered nurse (RN) signature and documentation of training or competencies of the following delegated tasks: -return demonstration of administration of oral medications; -return demonstration of administration of eyedrop medications; -return demonstration of administration of inhalation medications; -return demonstration of administration of topical medications; -return demonstration of administration of transdermal medications; and -return demonstration of administration of medications with other routes. ULP-C's employee record included an Educare (online training) transcript dated March 3, 2025, indicating ULP-C had not completed any training related to medication administration. ULP-C's record included a Staff Supervision dated October 22, 2024, indicating a registered nurse observed ULP-C successfully administering	0 650		

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0 650	Continued From page 16 medications. ULP-D ULP-D was hired December 4, 2024, and began providing assisted living services. ULP-D's record included a Care Fundamentals - Orientation Checklist dated December 10, 2024. Under the treatments and therapies section (pages 4-5), the checklist indicted ULP-D had completed return demonstrations of medication administration. The checklist lacked a signature of a registered nurse. ULP-D's record included a Staff Supervision record dated December 20, 2024, indicating a RN has observed ULP-D successfully administering medication. On March 4, 2025, at 10:16 a.m., ULP-C stated he had received medication administration training from the RN, and she had observed them passing medications to the resident. On March 4, 2025, at 11:13 a.m., owner/director (O/D)-A stated they had provided the orientation training by talking through the competency areas on the orientation checklist with ULP-C and ULP-D. O/D-A stated the RN did not participate in the orientation training. O/D-A stated they tried to get training transcripts from ULP-C's previous employer and were unable to obtain the training transcripts. The licensee did not have any policies addressing orientation and training of unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 650		

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0 650	Continued From page 17 (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included maintaining a current Facility Risk TB Risk Assessment and baseline TB screening for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 660		

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0 660	Continued From page 18 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 lacked a Facility TB Risk Assessment as required by the Minnesota Department of Health (MDH). ULP-C ULP-C was hired on October 21, 2024, and began providing assisted living services. ULP-C's employee record included a TB history and symptom screen completed October 22, 2024, and a negative chest x-ray completed on October 14, 2024. ULP-C's record lacked a two-step tuberculin skin test (TST) or a single QuantiFERON Gold test (a TB blood test) predating the chest x-ray. ULP-C's record lacked a symptom screen and TB history. ULP-D ULP-D was hired on December 4, 2024, and began providing assisted living services. ULP-D's employee record lacked a TB history and symptom screen and a two-step tuberculin skin test (TST) or a single QuantiFERON Gold test (a TB blood test). On March 4, 2025, at 8:56 a.m., owner/director (O/D)-A stated ULP-D did not have TB screening completed at the time of hire as they thought it was not required since ULP-D was born in the United States.	0 660		

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0 660	Continued From page 19 On March 4, 2025, at 9:59 a.m., O/D-A stated they were not aware a TST or QuantiFERON Gold test was required as part of TB screening. On March 4, 2025, at 11:54 a.m., O/D-A stated they did not have a Facility TB Risk Assessment and did not know it was required. O/D-A stated she did not have a TB screening and prevention policy. On March 4, 2025, at 15 p.m., surveyor observed O/D-A on the phone and when the call was disconnected, O/D-A walked to the printer and retrieved a TB policy which was presented to the surveyor. O/D-A stated their consultant had sent the policy. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's undated, unsigned TB Prevention and Control policy indicated the licensee would complete a written TB risk assessment for the facility with an annual review. The policy also indicated all employees would be screened for TB upon hire to include a history and symptom assessment and a TST or TB blood test.	0 660		

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0 660	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required	0 680		

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0 680	Continued From page 21 content for staff, residents, and visitors to view. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 3, 2025, at 11:13 a.m., owner/director (O/D)-A provided surveyor with the [Licensee] Emergency Preparedness Plan dated September 24, 2024. O/D-A stated this was the facility's EPP. The EPP lacked evidence of the following required information: - development of strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - quarterly review of the missing resident plan; - development of policy/procedure (P/P) for at minimum food, water and pharmaceutical supplies; - development of P/P for sewage and waste disposal; - development of P/P for system to track the location of on-duty staff and sheltered residents; - development of P/P for if on-duty staff and sheltered residents are relocated, how the licensee must document the specific name/location of the receiving facility or other location; - development of P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records;	0 680		

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0 680	Continued From page 22 - development of a communication plan to include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - development of a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and - development of a communication plan which included: - method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) development of P/P to address: use of volunteers, including the process/role for integration; and -documentation of exercises conducted at least twice per year to test the emergency preparedness plan. On March 4, 2025, at 12:51 p.m., owner/director (O/D)-A stated the EPP was not complete, and they were unsure of what information needed to be included in the plan. O/D-A stated they did not conduct disaster drills over the past year. The licensee did not have a policy addressing emergency preparedness or disaster planning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 23 (21) days	0 680		
0 790 SS=E	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 maintain the portable fire extinguishers as required by statute. This had the potential to directly affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On March 4, 2025, at 1:30 p.m., the surveyor toured the facility with owner/director (O/D)-A.	0 790		

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	40727	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HEALTH CARE LLC	4501 WINCHESTER LANE BROOKLYN CENTER, MN 55429

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0 790	Continued From page 24 During the facility tour, the surveyor observed monthly inspections were not recorded on the back of the tags attached to the portable fire extinguishers. During the facility tour interview, O/D-A verified monthly fire extinguisher inspections had not been completed. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, that it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect one resident and all staff. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 25 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 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: On March 4, 2025, at 1:30 p.m., the surveyor toured the facility with owner/director (O/D)-A. During the facility tour, the surveyor observed the following: - The wood fence on the side of the building had exposed nails, creating a safety risk to residents. - When the gate for the wood fence was opened, the bottom of the gate was catching on the sidewalk. The fence gate must be maintained in proper operating condition. - The sidewalk was chipped, creating a trip/fall hazard to residents. - A rope was used to secure the gate in the closed position. Hardware for opening and closing fence gates must be maintained as operable. During an interview on March 4, 2025, at 3:00 p.m., O/D-A verified the fence, gate, and sidewalk required repair. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 26 (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 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 27 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 potential to affect a large portion or all of the residents). The findings include: On March 4, 2025, owner/director (O/D)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated October 13, 2024, was a template from a third party provider and had not been developed with procedures specific to the facility and the building occupants. 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 employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The plan inappropriately referenced smoke compartment doors, fire sprinklers, and fire doors on magnetic holders, in a building without these types of life safety systems or a fire resistant construction type. The FSEP did not identify specific fire protection actions for residents evident by no procedures in the plan. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by no procedures in the plan. During an interview, on March 4, 2025, at 2:45 p.m., O/D-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to	0 810		

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0 810	Continued From page 28 provide training to employees on the FSEP upon hire evident by the lack of documentation. During an interview on March 4, 2025, at 2:45 p.m., O/D-A stated they did not know employee training on the FSEP was required at the time of hire and verified this had not been completed. 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 health facility identification number (HFID) for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 910		

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0 910	Continued From page 29 or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the licensee on October 9, 2024, and began receiving assisted living services. R1's Service Plan signed on October 14, 2024, indicated R1 received services for meal assistance, medication administration, and smoking supervision, R1's Assisted Living Contract signed on October 11, 2024, lacked the licensee's HFID 40727. On March 3, 2025, at 1:03 p.m., surveyor reviewed R1's contract with owner/director (O/D)-A. They stated this is the standard contract that will be used with all future residents. O/D-A stated the health facility identification number (HFID) was not included in the contract and was not aware this was required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:	0 950		

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0 950	Continued From page 30 "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the following verbatim notice to identify a designated representative for one of one resident (R1). This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the client 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 the clients).	0 950		

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0 950	Continued From page 31 The findings include: R1 was admitted on October 9, 2024, and began receiving assisted living services. R1's contract signed October 11, 2024, lacked authentication acknowledging receipt of the Designated Representative notice and lacked authorization or declination to name a designated representative. R1's record lacked a Designated Representative form separate from the contract. On March 3, 2025, owner/director (O/D)-A stated they did not provide R1 with a Designated Representative verbatim notice but discussed it with him when he signed the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 970		

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0 970	Continued From page 32 licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted on October 9, 2024, and began receiving assisted living services. R1's Service Plan signed October 14, 2024, indicated R1's services included meal preparation, medication administration, and smoking supervision. R1's record included an Independent/Assisted Living Contact signed October 11, 2024. Under section VI. General Terms (page 15), 2. Indemnification, the contract read "Resident will indemnify and hold harmless Provider, its employees, and agents from and against all claims, actions, damages, and liability and expense in connection with loss of life, personal injury, or damages to property arising from or out of the use by Resident of the rented premises, or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident ... 4. Liability: Provider is not liable to resident ... for any injury, death, or property damage occurring in the apartment unit or on Provider's premises unless such injury, death, or property	0 970		

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0 970	Continued From page 33 damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by the resident..." On March 3, 2025, at 1:03 p.m., surveyor reviewed R1's contract with owner/director (O/D)-A. They stated this is the standard contract that will be used with all future residents. O/D-A stated they were not aware the contract included waiver of liability language. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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; (7) standby assistance techniques and how to perform them;	01370		

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01370	Continued From page 34 (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 interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of two unlicensed personnel (ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-C ULP-C was hired on October 21, 2024, and	01370		

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01370	Continued From page 35 began providing assisted living services. ULP-C's employee record included a Care Fundamentals Orientation checklist dated October 7, 2024. The checklist lacked authentication indicating a registered nurse (RN) had provided training. The checklist lacked evidence of training/competency in the following areas: -documentation requirements for all services provided; -reports of changes in resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood borne pathogens; -maintenance of a safe and clean environment; -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting. ULP-D ULP-D was hired on December 4, 2024, and began providing assisted living services. ULP-D's employee record included a Care Fundamentals Orientation Checklist dated December 10, 2024. The checklist was signed and dated by owner/director (O/D)-A and lacked authentication indicating a registered nurse (RN) had provided training. On March 4, 2025, at 11:13 a.m., owner/director (O/D)-A stated they had provided the orientation training by talking through the competency areas on the orientation checklist with ULP-C and	01370		

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01370	Continued From page 36 ULP-D. O/D-A stated the RN did not participate in the orientation training. O/D-A stated they tried to get training transcripts from ULP-C's previous employer and were unable to obtain the training transcripts. The licensee did not have any policies addressing orientation and training of unlicensed staff. 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 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency	01380		

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GREAT HEALTH CARE LLC	4501 WINCHESTER LANE BROOKLYN CENTER, MN 55429

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01380	Continued From page 37 evaluations included all the required training for two of two unlicensed personnel (ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-C ULP-C was hired on October 21, 2024, and began providing assisted living services. ULP-C's employee record included a Care Fundamentals Orientation checklist dated October 7, 2024. The checklist lacked authentication indicating a registered nurse (RN) had provided training. The checklist lacked evidence of training/competency in the following areas: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. ULP-D ULP-D was hired on December 4, 2024, and began providing assisted living services. ULP-D's employee record included a Care Fundamentals Orientation Checklist dated December 10, 2024. The checklist was signed and dated by owner/director (O/D)-A and lacked authentication indicating a registered nurse (RN)	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40727	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HEALTH CARE LLC	4501 WINCHESTER LANE BROOKLYN CENTER, MN 55429

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01380	Continued From page 38 had provided training. On March 4, 2025, at 11:13 a.m., owner/director (O/D)-A stated they had provided the orientation training by talking through the competency areas on the orientation checklist with ULP-C and ULP-D. O/D-A stated the RN did not participate in the orientation training. O/D-A stated they tried to get training transcripts from ULP-C's previous employer and were unable to obtain the training transcripts. The licensee did not have any policies addressing orientation and training of unlicensed staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01530		

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01530	Continued From page 39 eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia 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 provide employees with the initial eight (8) hours of dementia training within 160 hours of providing direct care to residents for one of two direct care employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-C was hired on October 21, 2024, and began providing assisted living services. ULP-C's employee record included a Care Fundamentals Orientation Checklist dated October 7, 2024. The section Training Required Related to Dementia (page 3) included checkmarks beside the training modules and lacked time spent on each module and a	01530		

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01530	Continued From page 40 completion date. ULP-C's record included an Educare (online training) transcript dated March 4, 2025, indicating ULP-C did not complete any online training modules related to dementia care. On March 3, 2025, at approximately 11:30 a.m., indicating ULP-C was scheduled to work 35 hours per week. Owner/director (O/D)-A stated this was a weekly recurring schedule and confirmed ULP-C had worked for licensee since October 2024. On March 4, 2025, at 10:45 a.m., owner/director (O/D)-A stated ULP-C did not have dementia care training assigned or provided at the time of hire. O/D-A stated they do not have training information from ULP-C's prior employer, so online training modules had been assigned that day for employee to complete. The licensee's undated Dementia Training and Disclosure Requirements policy read "[licensee] provides required dementia training to all direct care staff and their supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."	03090		

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	40727	A. BUILDING: _____ B. WING _____	03/05/2025

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03090	Continued From page 41 (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 3, 2025, at 10:00 a.m., the surveyor observed the main entrance when entering the facility. The main entrance and interior commons area lacked signage for electronic monitoring with the required verbatim notice to visitors. The surveyor observed cameras in the common areas of the residence. On March 3, 2025, at 11:02 a.m., owner/director (O/D)-A stated the cameras in the residence provided audio and video monitoring. O/D-A stated they were unaware of the verbatim language required on electronic monitoring postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 42 (21) days	03090		

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/03/25*
Time: 12:00:13
Report: 1050251044

Food and Beverage Establishment Inspection Report

Location:
GREAT HEALTH CARE LLC
4501 WINCHESTER LANE
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0044094
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

FACILITY IS MISSING MN CFPM CERTIFICATE. DISCUSSED MN REQUIREMENTS. PROVIDED MDH LINK TO SECURE CERTIFICATE.

TAIWO ODENIYI DOES HAVE A CURRENT FOOD PROTECTION MANAGER CERT EXP. DATE 11/16/28 POSTED IN THE HOME.

Comply By: 05/06/25

Surface and Equipment Sanitizers

Hot Water: = at 163.8F Degrees Fahrenheit
Location: Diswasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/Bacon
Temperature: 40F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Bologna
Temperature: 41F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Type: Full
Date: *03/03/25*
Time: 12:00:13
Report: 1050251044
GREAT HEALTH CARE LLC

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

This inspection was the operator and reviewed with MDH Nurse Evaluator Michelle Winters.

1/5 clients are in the home at this time. No leftover s are kept on site after cooking.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen had laminate cabinets, laminate counter tops, wood floor and popcorn ceilings. All kitchen surfaces were well maintained and cleaned.

2 basin sink is located in the kitchen with one designed for hand washing.

Discussed final cook temps, temp control, cooling, re heating, ware washing, hand washing, date marking, cleaning, glove use, sanitizer, food storage, illness policy, and food handling procedures.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department Of Health inspection report number 1050251044 of 03/03/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Taiwo Odeniyi
Operator

Signed:_____
Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us