Electronically Delivered

October 20, 2026

Licensee
Divine Assisted Living Services
3307 O'Henry Road
Brooklyn Center, MN 55429

RE: Project Number(s) SL36163016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 23, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

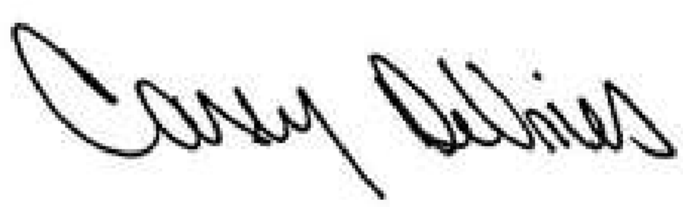
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,



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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36163	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ASSITED LIVING SERVICES	3307 O'HENRY ROAD BROOKLYN CENTER, MN 55429

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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: SL36163016-0 On September 21, 2026, through September 23, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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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0 340	Continued From page 1	0 340		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute their plan of correction (POC) following their previous routine and follow up (LOF) surveys concluded on July 25, 2024, and November 6, 2024. 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	0 340		

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0 340	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee received their correction orders via electronic delivery on August 20, 2024, following their July 25, 2024, survey, and December 11, 2024, following their LOF survey. The longest period for correction on the correction orders from the date of receipt was 21 days. MN Statute 144G.30 Subd. 5 (c) (1) indicates by the correction order date; the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon complaint investigation, and as otherwise needed. On September 21, 2026, through September 23, 2026, the Minnesota Department of Health conducted a routine survey and re-issued correction orders related to the following: - maintain a tuberculosis (TB) prevention and control program, - smoke alarms, - fire safety and evacuation plan, - annual training, - medications error, and - no medication open date. The licensee's POC dated October 24, 2024, indicated the licensee had made corrections and put systems in place to mitigate all the identified issues. The POC further indicated that registered	0 340		

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0 340	Continued From page 3 nurse (RN) will review all correction orders upon receipt and ensure corrective actions are completed, documented, and maintained in facility records by the required correction date. Documentation will remain readily available for review during future surveys, complaint investigations, and regulatory requests. However, the records did not include information to demonstrate audits completed by licensed assisted living director (LALD), TB record audits, installation of working smoke alarms, and that the RN trained staff and audited medications to ensure compliance as documented in the POC. On September 23, 2026, at 11:50 a.m., clinical nurse supervisor (CNS)-A stated they started with licensee on January 28, 2026, and that they were following up on the POC to ensure all issues noted there were corrected. When the surveyor asked about the re-issued tags, CNS-A stated they would need to investigate what happened. Owner/unlicensed personnel (O/ULP)-B stated they had worked with a paid consultant and that they followed through and implemented all suggestions they were given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
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	0 480		

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0 480	Continued From page 4 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb	0 480		

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0 480	Continued From page 5 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 22, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510	Continued From page 6	0 510		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 22, 2026, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C	0 510		

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0 510	Continued From page 7 brought R3's medications to his room for administration. ULP-C completed hand hygiene and applied gloves. ULP-C gave R3 prescribed eye drops. ULP-C then left R3's room with medications, unlocked the office door, unlocked and opened the medication cabinet, got a medication cup, and returned to the resident's room to complete medication administration. ULP-C did not complete hand hygiene or change their gloves after returning to the room and administering additional medications. On September 22, 2026 at 8:45 a.m., ULP-C stated they should have changed their gloves after touching the keys and door handle. ULP-C stated they had a lot in their hands and just forgot. On September 23, 2026, at 8:17 a.m., clinical nurse supervisor (CNS)-A stated a staff person should complete hand hygiene and change gloves after touching any contaminated surface. Licensee's policy titled 8.07 Gloves, dated January 1, 2026, indicated gloves must be worn whenever there may be direct contact between an employee and contaminated objects or as instructed. The Centers for Disease Control and Prevention's (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, indicated gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Also indicated change gloves if moving from a soiled body site to a clean body site on the same patient and before exiting a patient room.	0 510		

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0 510	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include TB history and symptom screen and a TB two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 9 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-C ULP-C started employment with the licensee on March 1, 2021, to provide assisted living services. On September 22, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2. ULP-C's record included a first step positive TST dated September 8, 2024, and chest Xray (CXR) dated October 10, 2024. ULP-C's record lacked a TB history and symptom screening and a second step TST. ULP-D ULP-D started employment with the licensee on July 15, 2024, to provide assisted living services. ULP-D's record included a two-step negative TST dated July 19, 2024, and October 7, 2024. ULP-D's record lacked a TB history and symptom screening. On September 23, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated they had completed TB history and symptom screening, and that probably they had misplaced the record in the office. CNS-A also stated they thought	0 660		

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0 660	Continued From page 10 there was no need for two step TST as the first was positive. The licensee's Tuberculosis Screening policy dated January 1, 2026, indicated the licensee will 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 (MMWR). The policy also indicated that new staff will have an Interferon Gamma Release Assay (IGRA) blood test or a two-step Mantoux conducted with results documented on the baseline TB screening tool for health care workers (HCWs). The Minnesota Department of Health's Assisted Living FAQs: Staff Requirements dated September 11, 2026, indicated baseline TB screening includes assessing for current symptoms of active TB disease, assessing TB history, and testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The FAQs also indicated CXR alone is not acceptable documentation. You either need documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and a CXR with provider evaluation after that date, or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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DIVINE ASSITED LIVING SERVICES	3307 O'HENRY ROAD 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
0 660	Continued From page 11 (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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0 780	Continued From page 12	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 780		

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0 780	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 14 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 observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810		

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0 810	Continued From page 15 Environment Inspection Report (PEIR) dated September 22, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services	01500		

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01500	Continued From page 16 and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C, 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	01500		

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01500	Continued From page 17 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: ULP-C ULP-C started employment with the licensee on March 1, 2021, to provide assisted living services. ULP-C's training transcript dated January 1, 2026, indicated ULP-C had completed annual training for a total of 5 hours in the following topics: - reporting maltreatment of vulnerable adults or minors - 0.5 hours; - Assisted Living Bill of Rights - 0.5 hours; - infection control techniques - 0.75 hours; - principles of person-centered planning/service delivery - 0.25 hours; - dementia training - 2 hours; and - mental illness and de-escalation training - 1 hour. ULP-D ULP-D started employment with the licensee on July 15, 2024, to provide assisted living services. ULP-D's training transcript dated January 1, 2026, indicated ULP-D had completed annual training for a total of 5.25 hours in the following topics: - reporting maltreatment of vulnerable adults or minors - 0.5 hours; - Assisted Living Bill of Rights - 0.5 hours; - infection control techniques - 0.75 hours; - principles of person-centered planning/service delivery - 0.25 hours; - dementia training - 2 hours; and	01500		

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01500	Continued From page 18 - mental illness and de-escalation training - 1.25 hour. ULP-C and ULP-D's employee record lacked the following required topics: - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - review of provider's policies and procedures. On September 23, 2026, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated all employees had been assigned annual training and that they audited the records to ensure training was completed. CNS-A also stated that they were aware they needed to have at least eight hours of annual training. CNS-A stated Residex (training software) assigned them training topics and that they were not aware they were missing the topics above. CNS-A further stated all employees will be missing the required annual eight hours of annual training in the required topics and that they will be missing on the two topics identified above. The licensee's Annual Required Staff Training policy dated January 1, 2026, indicated all staff that perform direct care services at the [licensee] will complete at least eight (8) hours of annual training for each 12 months of employment. The policy also included the missing topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01750	Continued From page 19	01750		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the administration of resident medications by unlicensed personnel (ULP) followed acceptable standards for one of one employee (ULP-C) observed during medication pass. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's service plan dated January 16, 2026, indicated R3 received services to include medication administration.	01750		

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01750	Continued From page 20 R3's provider orders signed August 9, 2026, indicated R3 was to receive the following eye drops: - Brimonidine 0.1% instill one drop in the left eye three times a day for Glaucoma; - Dorzolamide Hydrochloride and Timolol Maleate 2-0.5% (Dorzol/Timol) ophthalmic solution instill one drop into left eye twice a day for Glaucoma; and - Refresh ophthalmic solution instill one drop into both eyes four times daily for Glaucoma. On September 22, 2026, at 8:20 a.m., the surveyor observed ULP-C enter R3's room for morning medication administration. At 8:26 a.m., ULP-C administered one drop of Refresh ophthalmic solution into each eye. ULP-C started a timer on their phone for two minutes and stated they wait one to two minutes between administration of eye drops. At 8:30 a.m., ULP-C administered one drop of brimonidine eye drops to the left eye. At 8:32 a.m., ULP-C administered one drop of Dorzol/Timol ophthalmic solution to the left eye. Product insert for Brimonidine tartrate ophthalmic solution included dosage and administration instructions to instill different products at least five minutes apart when more than one product is used. Product insert for dorzolamide hydrochloride and timolol maleate ophthalmic solution included dosage and administration instructions to instill different products at least five minutes apart when more than one product is used. On September 22, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated they provide	01750		

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01750	Continued From page 21 training for medication administration and advised staff to wait "a few minutes" between eye drops when the resident receives more than one but did not specify how long staff should wait. Licensee's policy for Eye drops and Eye Ointment dated June 1, 2021, indicated staff should reference the medication reference manual if they have questions about the medication they are giving. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments permitted only authorized personnel to access. 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01880		

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01880	Continued From page 22 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 22, 2026, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-C remove R2's medications from locked medication cabinet in facility office. ULP-C left the office, pulling the door closed. The office door opened due to not being properly secured and locked while R2 was standing outside of office door. No additional staff were in the vicinity of the unsecured medications. The surveyor observed medications on the office desk through the open door before ULP-C returned. On September 22, 2026, at 9:00 a.m., ULP-C stated they usually make sure all medications are secured before walking away. ULP-C stated they were not aware the door was not fully secured. On September 23, 2026, at 11:10 a.m., clinical nurse supervisor (CNS)-A stated all medications should be secured in locked office. Licensee's policy for Medication Storage, dated January 1, 2026, indicated all medications would be kept securely locked and stored per manufacturer's directions. Only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 23	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time-sensitive medications included the opened or expiration date. 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 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 September 22, 2026, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C administer morning medications including eye drops for R3. None of the eye drop bottles in R3's medication box had open dates written on them. R3's provider orders signed August 9, 2026, indicated R3 was to receive the following eye drops: - Brimonidine 0.1% instill one drop in the left eye	01890		

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01890	Continued From page 24 three times a day for Glaucoma; - Dorzolamide Hydrochloride and Timolol Maleate 2-0.5% (Dorzol/Timol) ophthalmic solution instill one drop into left eye twice a day for Glaucoma; - Latanoprost 0.005% solution instill one drop in left eye every night at bedtime for Glaucoma. Brimonidine 0.1% solution had a pharmacy prescription label with a dispense date of July 29, 2026. Neither bottle nor pharmacy prescription label had an open date written on it. Product insert for Brimonidine 0.1% solution did not include discard guidance for medication. Dorzol/Timol ophthalmic solution had a pharmacy prescription label with a dispense date of August 17, 2026. Neither bottle nor pharmacy prescription label had an open date written on it. Product insert for Dorzol/Timol ophthalmic solution indicated medication bottle should not be used after expiration date on the bottle. Latanoprost 0.005% solution had a pharmacy prescription label with a dispense date of June 2, 2026. Neither bottle nor pharmacy prescription label had an open date written. Product insert for Latanoprost 0.005% solution indicated medication bottle should be discarded six weeks once bottle is opened and stored at room temperature. On September 22, 2026, at 11:30 a.m. clinical nurse supervisor (CNS)-A stated they did not typically date eye drop bottles when they open them. CNS-A stated they typically discarded the previous bottle monthly when a new shipment from the pharmacy arrived. CNS-A stated there	01890		

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01890	Continued From page 25 was no way they could track when the bottles eye drop were opened. Licensee's policy for Eye drops and Eye Ointment dated June 1, 2021, indicated staff should reference the medication reference manual if they have questions about the medication they are giving. Licensee's policy failed to include instructions on dating eye drop bottles when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
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Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

DIVINE HOME CARE SERVICES LLC
3307 O'HENRY ROAD
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36163

Risk:
License:
Expires on:
CFPM: Assata Hajah Sheriff
CFPM #: 42454; Exp: 11/27/2027

Inspection Info

Report Number: F1043261281
Inspection Type: Full - Single
Date: 9/22/2026 Time: 4:29:34 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: RAW SHELL EGGS STORED ON SHELF ABOVE READY-TO-EAT FOODS IN FRIDGE. ADVISED STAFF TO RELOCATE RAW FOODS TO BOTTOM OF FRIDGE. STAFF CORRECTED ON SITE. COMPLY WITH ABOVE RULE.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: WET CLOTH STORED ON KITCHEN COUNTER. PER STAFF, CLOTH IS USED THROUGHOUT THE DAY. ADVISED STAFF TO STORE WET CLOTH IN APPROVED SANITIZER IN BETWEEN USES OR TO USE A DRY, CLEAN CLOTH EACH TIME. STAFF CORRECTED ON SITE. COMPLY WITH ABOVE RULE.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

Food & Beverage General Comment

Inspection was completed with Benard Nyangena as the lead Health Regulation Division Nurse Evaluator.

TEMPERATURE (F)
KITCHEN FRIDGE: MILK 38, BUTTER 40, DELI MEAT 40

UTENSIL SURFACE TEMPERATURE (F)
DISH MACHINE: TESTED BY FACILITY EVERY DAY, TEST LAST RUN ON 9/21/2026 MEASURED 160F.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, same day food service, cleaning, pest control, test kits, food storage, and food handling procedures.

Facility has a residential kitchen: wooden cabinetry, laminated flooring & countertop, smooth walls, textured ceilings, and Amana dish machine. Conditions of equipment and physical facility will be monitored during future inspections – must be brought up to code if at such time they are found to be a concern or risk of contamination.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1043261281 from 9/22/2026

Assata Hajah Sheriff
CFPM

Blia Lor,
Public Health Sanitarian
651-355-0641
blia.lor@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36163016-0	**Date:** September 22, 2026
Facility Name: DIVINE HOME CARE SERVICES LLC	
Facility Address: 3307 Ohenry Rd, Minneapolis, Minnesota 55429	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

2. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

   Comments: The facility failed to provide smoke alarms with Underwriters Laboratory (UL) 217 standard. Nowhere on the alarms indicated that they were listed as UL 217.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: Unlicensed personnel (ULP)-B tested the smoke alarms for interconnection. The alarms located upstairs, basement, living room, and bedrooms failed to activate when alarm in kitchen was activated.

DEPARTMENT OF HEALTH

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The posted fire evacuation diagrams lacked the location and number of resident sleeping rooms. The FSEP binder lacked any plans or diagrams showing the location and number of resident sleeping rooms.

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

   Comments: The licensee failed to provide training documentation to show employees were trained on the FSEP upon hire and at least twice per year.