STATE LICENSING COMPLIANCE REPORT

Report #: HL383502903C **Date Concluded:** September 21, 2026

Name, Address, and County of Facility Investigated:
MAS Home Health Care
8019 Upton Avenue South
Bloomington, MN 55431
Hennepin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Barbara Axness, RN

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38350	A. BUILDING: _____ B. WING _____	C 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAS HOME HEALTH CARE LLC	8019 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL383502903C On July 15, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL383502903C, tag identification 0430, 0770, 0775, 0780, 800, 0830, 1480, 1620, 2290	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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services and amenities provided by the licensee. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than 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:	0 430		

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0 430	Continued From page 2 The licensee's UDALSA dated February 21, 2026, indicated in addition to a registered nurse (RN) who was required to be accessible to staff 24/7, licensed staff were in the building, an attached building, or within the campus and available to respond to resident requests 24/7. The UDALSA indicated the facility had a library and washers and dryers in units. Staff were also trained to use Cardiopulmonary Resuscitation (CPR). On July 15, 2026, the investigator observed the facility and two resident rooms, R1 and R2. The investigator did not observe washers or dryers in either unit. The investigator did not observe a library in the facility. On July 20, 2026, at 1:45 p.m. owner (O)-B stated they had a RN that worked four hours per week but they were not required to have a RN in the facility 24/7. O-B confirmed the UDALSA was not correct that there was a RN onsite 24/7 in addition to the RN on call. O-B confirmed the facility did not have washers and dryers in units as indicated on the UDALSA. O-B confirmed the facility also did not have a library as indicated in the UDALSA. O-B stated facility staff were trained by a nurse to do CPR and they had records that could be sent. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		

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0 770	Continued From page 3	0 770		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. 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:	0 770		

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0 770	Continued From page 4 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 770		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, 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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 15, 2026, for the specific violations related the	0 775		

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0 775	Continued From page 5 physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
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	0 780		

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0 780	Continued From page 6 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 July 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure 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 July 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity	0 830		

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0 830	Continued From page 8 of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's assessment dated May 8, 2026, indicated R2 smoked a pack of cigarettes a day but did not identify how many times per day he smoked or where he smoked. At the time of the assessment, there were no signs of mishandled cigarettes in his room or burns in the carpet. It was determined R2 could smoke safely, independently, and without intervention. On July 15, 2026, at 10:00 a.m., the investigator observed R2's room with the resident present. On a bedside table next to his bed was a pack of cigarettes, several lighters, and an ash disposal cup. There was ash on the bedside table and the	0 830		

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0 830	Continued From page 9 bed frame and the room smelled of cigarette smoke. On the carpet next to R2's bed, the carpet appeared to have a burn mark. On July 15, 2026, at 10:30 a.m., unlicensed personnel (ULP)-D stated R2 would deny smoking in his room but confirmed he would sometimes smoke in his room. On July at 2:45 p.m., owner (O)-B stated R2 would smoke in his room and they would have to give warnings to him about smoking in the facility. On July 20, 2026, at 12:00 p.m., clinical nurse supervisor (CNS)-C stated she had never observed R2 smoking in his room but she was only at the facility four hours per week. CNS-C stated facility staff had not reported any concerns to her about R2 smoking in his room. CNS-C stated the burn on the carpet was likely from the resident who lived in the room prior to R2 as he would smoke in his room. On July 20, 2026, at 1:25 p.m., O-B stated there were residents who would remove batteries from smoke detectors in order to smoke in the facility. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited indoors of all public places to include health care facilities and clinics. MCIIA defined "Indoor Area" to be "a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (open or closed) around the perimeter. A wall includes retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. A (standard) window screen is not a wall."	0 830		

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0 830	Continued From page 10 Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The licensee's undated Resident Smoking/Tobacco Use policy indicated smoking in the facility was prohibited, including in resident rooms and common indoor areas. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 830		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to individual residents for one of one residents (R1).	01480		

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01480	Continued From page 11 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: R1's diagnoses included general anxiety disorder and depression. R1's unsigned service plan dated February 12, 2026, indicated the facility provided behavior management services three times per day for R1's agitation, anxiety, self isolation, and verbal aggression. R1's assessment dated May 22, 2026, indicated R1 had the following behaviors: agitation when angry, verbal aggression when agitated, anxiety that was generalized, depression, and had the recent loss of a pet after giving up her dog. The assessment did not describe any triggers to her behaviors or have any interventions listed for how staff should manage and respond to her behaviors. Interventions listed in R1's Customized Living Rates Worksheet were not incorporated into R1's plan of care. On July 20, 2026, documentation related to staff being oriented to R1 and the services she received was requested. On July 20, 2026, at 2:47 p.m., licensed assisted living director in residence (LALDIR)-A wrote, "We do not have documentation showing staff	01480		

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01480	Continued From page 12 training specific to [R1]. We train our staff on how to manage behaviors holistically for all residents, and we then transition into oral training regarding what to expect and how to handle specific situations for each resident as reflected in the behavioral plan." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and	01620		

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01620	Continued From page 13 (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for one of one residents (R1). R1 had a documented history of behaviors related to agitation, anxiety, self-isolation, and verbal aggression. The RN failed to assess or include any information or interventions related to R1's behaviors. The facility later attempted to discharge R1 due to issues related to her behaviors.	01620		

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	38350	A. BUILDING: _____ B. WING _____	C 07/15/2026

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01620	Continued From page 14 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: R1's diagnoses included general anxiety disorder and depression. R1's unsigned service plan dated February 12, 2026, indicated the facility provided behavior management services three times per day for R1's agitation, anxiety, self isolation, and verbal aggression. R1's Customized Living Rates Worksheet completed by the Minnesota Department of Human Services provided by her case manager indicated the facility was to socialize with the resident one to three hours per day with the goal of taking her mind off feeling lonely and learning stabilization/coping techniques, and to help sharpen memory and cognitive skills. R1 was to attend daily programs and activities at the facility and address unhelpful thought patterns through cognitive behavioral therapy focusing on challenging and changing unhelpful cognitive distortions and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. The worksheet indicated "staff must be supportive when intervening during her phase. Attempt to focus on assisting [R1] to explore information that will help them see the problem is	01620		

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01620	Continued From page 15 solvable. Avoid confrontations during panic attacks." Notes on the worksheet indicated R1's mental health crisis can't always communicate her thoughts, feelings, or emotions clearly and she may find it difficult to understand what others are saying....This can be hard at times but staff need to have the proper skills and leadership in order to maintain their positions as caretakers." Interventions listed included keeping your voice calm, avoid overreacting, listening, don't aruge or reason with her, keep stimulation level low, offer options instead of trying to take control, avoid touching unless asked for permission, gently announce actions before initiating them, give the person space. R1's assessment dated May 22, 2026, indicated R1 had the following behaviors: agitation when angry, verbal aggression when agitated, anxiety that was generalized, depression, and had the recent loss of a pet after giving up her dog. The assessment did not describe any triggers to her behvaiors or have any interventions listed for how staff should manage and respond to her behaviors. Interventions listed in R1's Customized Living Rates Worksheet were not incorporated into R1's plan of care. R1's record contained a document titled Notice of Termination of Assisted Living Contract (Housing) dated July 13, 2026. R1 had a case manager involved in her care, however they were not listed on the notice. The reason for termination was due to R1 dumping and destroying all household groceries and being verbally aggressive towards staff. Staff were unable to de-escelate the situation and staff expressed fear of retaliation in attempting to do so. Two other incidents were noted to have occured. One on February 23, 2026, and another on March 13, 2026. The	01620		

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01620	Continued From page 16 proposed termination date was August 13, 2026. A pre termination meeting was to be held on July 20, 2026. The document was noted to have been delivered to R1 in person however it was not signed by her or the licensed assisted living director. R1's record also contained a document titled Second Warning- Behavioral Contract Violation dated March 16, 2026. It indicated "you have now breached the Behavioral Contract on two separate occasions." The first violation on February 23, 2026, indicated R1 failed to properly care for an animal on the premises. The Behavioral Contract explictly states that no animals are allowed inside the facility. The second violation on March 13, 2026, indicated there was a verbal altercation with a staff member, including threatening to cause physical harm and calling the staff member a liar. "The Behavioral Contract explicitly states there shall be no verbal or physical algercation with staff or residents." It was noted this was R1's final warning and "any further breach of the Behavioral Contract will result in the immediate termination of your tenancy and discharge from MAS Home Health Care LLC in accordance with Section 4 of your signed Behavioral Contract and applicable Minnesota regulations." On July 20, 2026, at 12:05 p.m., clinical nurse supervisor/registered nurse (CNS/RN)-C stated R1 had behaviors that would vary and she would get upset and aggressive with staff at times. CNS/RN-A stated from a mental health standpoint, they were just monitoring things. CNS/RN-C stated interventions for R1 included letting R1 release what she feels and don't interrupt her and give her space and to call administration so they can come talk to her.	01620		

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01620	Continued From page 17 CNS/RN-A stated she would have to check R1's assessment to see where she had assessed her behaviors. On July 23, 2026, at 11:30 a.m., licensed assisted living director in residence (LALDIR)-A stated he had entered the interventions that appeared on R1's service plan and that he had taken those interventions from R1's county rate worksheet. On July 23, 2026, at 12:30 p.m., R1 stated the facility did not know how to handle her mental health and they would make things worse if she was having a mental health crisis. R1 stated a staff member called her a crack head the other day because she had gotten most of her teeth removed and also had called her a bitch. R1 stated if she was having mental health concerns that triggered her behaviors, staff would tell her if she didn't like it here she could leave and that there was nothing they could do for her. R1 stated the facility didn't do any therapeutic interventions or understand her behavioral health needs. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70,	01620		

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01620	Continued From page 18 subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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:	02290		

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02290	Continued From page 19 R1's record contained a document titled Behavioral Contract dated February 21, 2026. R1's record contained a document titled Notice of Termination of Assisted Living Contract (Housing) dated July 13, 2026. The reason for termination was due to R1 dumping and destroying all household groceries and being verbally aggressive towards staff. Staff were unable to de-escalate the situation and staff expressed fear of retaliation in attempting to do so. Two other incidents were noted to have occurred. R1's record also contained a document titled Second Warning- Behavioral Contract Violation dated March 16, 2026. It indicated "you have now breached the Behavioral Contract on two separate occasions." The first violation on February 23, 2026, indicated R1 failed to properly care for an animal on the premises. The Behavioral Contract explicitly states that no animals are allowed inside the facility. The second violation on March 13, 2026, indicated there was a verbal altercation with a staff member, including threatening to cause physical harm and calling the staff member a liar. "The Behavioral Contract explicitly states there shall be no verbal or physical altercation with staff or residents." It was noted this was R1's final warning and "any further breach of the Behavioral Contract will result in the immediate termination of your tenancy and discharge from MAS Home Health Care LLC in accordance with Section 4 of your signed Behavioral Contract and applicable Minnesota regulations." The document titled Behavioral Contract indicated: I do voluntarily agree that I will abide by all of the	02290		

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02290	Continued From page 20 following stipulations while residing at: 8019 Upton Ave S, Bloomington, MN 55437: -I will abide by all MAS Home Health Care Residential Living Standards, which include no alcohol or drug, no vehicle on premises without all legal paperwork (proof of Insurance, and registration of tag and title). -I will abide by all terms and conditions of my rental agreement; and -I agree to the following terms: 1. No verbal or physical altercation with the staff and residence. 2. No weapons are allowed inside the facility including pocket knives. 3. No profanities allowed inside the facility. 4. No verbal harassment or sexual acts towards residence and staff. 5. No smoking inside the facility including vapes. 6. No alcohol and drugs allowed in the facility. 7. No property damages 8. No animals allowed inside the facility. 9. You will abide by curfew schedule and no overnight passes unless approved by management. 10. complying with coordination of care. 11. If you come onto the premises from a pass intoxicated Case Manager, PCP and/or Psychologist will be updated via phone or fax of date of incident. I understand that if I breach any provisions of this contract, the Landlord may terminate my tenancy and evict me from my residence. On July 20, 2026, at 2:21 p.m., licensed assisted living director in residence (LALDIR)-A confirmed all residents were required to sign the behavior contract at the time of admission. No further information was provided.	02290		

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02290	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		