Electronically Delivered

October 19, 2026

Licensee
Residential Care Nine Mile Creek
10641 James Road
Bloomington, MN 55431

RE: Project Number(s) SL32061016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 3, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

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
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	10641 JAMES ROAD BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32061016-0 On August 31, 2026, through September 3, 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 six residents: all of whom received services under the Assisted Living license. An immediate correction order was identified on August 31, 2026, issued for SL32061016-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included assessing for current symptoms of active TB disease and assessing TB history, for three of three employees (unlicensed personnel (ULP)-A, ULP-B, ULP-G). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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).	0 660		

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0 660	Continued From page 2 The findings include: ULP-A ULP-A was hired on February 13, 2025, to provide direct care services to residents. R1's medication administration record (MAR) for the month of August 2026 indicated that ULP-A administered morning medication to R1 on August 27, and August 28, 2026. ULP-A's employee record included a negative QuantiFERON TB Gold plus result completed on February 10, 2025. ULP-A's employee record lacked evidence of an assessment for current symptoms of active TB disease, and an assessment for TB history. ULP-B ULP-B was hired on April 7, 2024, to provide direct care services to residents. R1's MAR for the month of August 2026 indicated that ULP-B administered evening medication to R1 on August 23, and August 30, 2026. ULP-B's employee record included a negative chest X ray result dated March 7, 2024. ULP-B's employee record lacked evidence of an assessment for current symptoms of active TB disease, and an assessment for TB history. ULP-G ULP-G was hired on June 19, 2026, to provide direct care services to residents. R1's Recorded Care Report for the month of August 2026, indicated that ULP-G provided a dressing reminder service to R1 on August 5, and	0 660		

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0 660	Continued From page 3 August 7, 2026. ULP-G's employee record included a negative QuantiFERON TB Gold plus result completed on April 4, 2026. ULP-G's employee record lacked evidence of an assessment for current symptoms of active TB disease, and an assessment for TB history. On September 1, 2026, at 1:10 p.m., clinical nurse supervisor (CNS)-C stated ULP-B was hired before them, and they did not know why the symptom and history screening was not completed. CNS-C then questioned if the Minnesota department of health requires employees to take the TB gold test or symptom screening. CNS-C stated they thought it was either symptom screening or TB gold test. CNS-C stated ULP-G was a new hire; ULP-G had worked with residents, but the screening was not done yet. Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed	0 660		

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0 660	Continued From page 4 after the HCW starts working with patients. The Licensee's 8.16 Tuberculosis Screening Policy dated June 30, 2021, read, "Staff Screening Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." 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	0 680		

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0 680	Continued From page 5 (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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 6 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: The licensee's undated EPP lacked the following required content: -policies and procedures for tracking staff and residents; -policies and procedures for medical documents; -policies and procedures for volunteers; -primary and alternate means for communication; and -procedure for sharing information on occupancy and or needs. On September 2, 2026, at 10:00 a.m., owner (O)-E stated the licensee was still working on updating their EPP to be compliant with state requirements. O-E stated they did not see medical documents and volunteers' policy in the EPP. O-E stated they remember writing communication plan, but they did not see it in the EPP. O-E stated they made a communication plan with a phone tree, but they did not know why it was not in the EPP. The licensee's Emergency Preparedness policy dated June 30, 2021, indicated the licensee has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance."	0 680		

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0 680	Continued From page 7 Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 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	0 810		

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0 810	Continued From page 8 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 Environment Inspection Report (PEIR) dated August 31, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 810		

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0 810	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one 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: On September 1, 2026, at 9:03 a.m., the surveyor observed a blank contract titled Assisted Living Lease Agreement. The licensee's Assisted Living	0 910		

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0 910	Continued From page 10 Contract lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. R1's Assisted Living Lease Agreement signed on May 30, 2026, lacked the following required content: - in a conspicuous place and manner on the contract the licensee's HFID#. On September 2, 2026, at approximately 1:20 p.m., owner (O)-E stated they used to put HFID# on the contract but not anymore. O-E did not know why they stopped including HFID#s on the contract. On September 2, 2026, at 1:35 p.m., O-E stated the blank contract was used for all residents who resided in the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of	0 930		

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0 930	Continued From page 11 residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content 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 potential to affect a large portion or all of the residents). The findings include: On September 1, 2026, at 9:03 a.m., the surveyor observed a blank contract titled Assisted Living Lease Agreement. The licensee's Assisted Living Lease Agreement lacked the following required content: - the right under section 144G.54 to appeal the termination of an assisted living contract. R1's Assisted Living Lease Agreement signed on May 30, 2026, lacked the following required	0 930		

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	32061	A. BUILDING: _____ B. WING _____	09/03/2026

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0 930	Continued From page 12 content: - the right under section 144G.54 to appeal the termination of an assisted living contract. On September 2, 2026, at approximately 1:20 p.m., owner (O)-E stated they were not aware they had to include the right under section 144G.54 to appeal the termination of an assisted living contract. On September 2, 2026, at 1:35 p.m., O-E stated the blank contract was used for all residents who resided in the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060		

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01060	Continued From page 13 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R5). 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	01060		

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01060	Continued From page 14 situation has occurred only occasionally). The findings include: R5 was admitted to the licensee on August 19, 2019, with diagnoses including seizures, hypertension, and type 2 diabetes mellitus. R5's service plan signed and dated May 12, 2026, indicated R5 received assistance with bathing, dressing, hygiene, grooming, medication administration, and managing agitation. R5's progress notes written on July 9, 2026, by clinical nurse supervisor (CNS)-C indicated R5 was admitted to the hospital on June 26, 2026, and returned to the facility following 10 days of hospitalization. R5's record lacked evidence of a written notice was provided that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal; and - a notice to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility	01060		

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01060	Continued From page 15 within four days. On September 3, 2026, at approximately 2:30 p.m., CNS-C stated they did not provide the emergency relocation form to R5. CNS-C also stated they had not notified the ombudsman about R5's relocation. CNS-C stated they were aware of the requirement to provide written notice with required contents for an emergency relocation and the requirement to notify the ombudsman if resident stayed out of the facility for more than four days. CNS-C stated that they had emergency relocation form that was supposed to be utilized for a residents' emergency relocation and provided the surveyor with a copy of blank emergency relocation form. CNS-C stated staff were supposed to complete the form, and they would retrain staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=D	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	01500		

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01500	Continued From page 16 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. 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,	01500		

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01500	Continued From page 17 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-B). 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: ULP-B was hired on April 7, 2024, to provide direct care services to residents. ULP-B's employee records included documentation of infection control training last completed on March 16, 2024. ULP-B's employee records lacked documentation of annual infection control training completed in 2025 and 2026. R1's medication administration record (MAR) for the month of August 2026, indicated that ULP-B administered evening medication to R1 on August 23, and August 30, 2026. On September 2, 2026, at approximately 12:50	01500		

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01500	Continued From page 18 p.m., owner (O)-E stated ULP-B was on a leave of absence and stated ULP-B was still working on completing their annual training. The licensee's 5.06 Annual Required Staff Training policy dated June 1, 2025, indicated the following training elements must be included every 12 months for all staff who perform direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557; 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand-washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01500		

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01500	Continued From page 19 (21) days	01500		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services assessed for five of five residents (R1, R2, R4, R5, R6). 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	01640		

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01640	Continued From page 20 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on March 12, 2026, with diagnoses that included schizophrenia and traumatic brain injury. R1's Support Plan effective September 1, 2025, through August 31, 2026, indicated the licensee was receiving reimbursement for the following services for R1: - dressing; - grooming; - bathing; - assistance with walking; - three meals and two snacks; - assistance with self-administration of medication; - verbal and visual medication reminders; - medication setups and monitoring; - summoning device; - managing wandering; - managing orientation issues; - managing anxiety; - managing repetitive behavior; - managing agitation; - managing self-injurious behavior; - managing verbal aggression; - managing physical aggression; - managing property destruction; - home making; - shopping; - assistance making appointments;	01640		

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01640	Continued From page 21 - arranging non-medical transportation; and - socialization. R1's service plan signed and dated March 26, 2026, indicated R1 received assistance with: - dressing; - continence; - personal laundry and housekeeping; - congregate meal; - transportation; - socialization; - delegated clinical monitoring; - manage agitation; and - manage anxiety. R1's service plan did not include following support plan services: - shopping; - appointment making; - transportation; - socialization; and - behavioral management. R1's Resident Care Report generated on September 1, 2026, for the month of august 2026, indicated R1 received the following documented services: - bathing reminders and moderate assistance; - dressing; - grooming; - medication administration; - food preparation; - dressing reminder; and - personal laundry assistance. R1's Resident Care Report did not include the following service plan items which were identified in the service plan: - continence; - transportation; - socialization;	01640		

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01640	Continued From page 22 - delegated clinical monitoring; - manage agitation; and - manage anxiety. On September 2, 2026, at approximately 2:20 p.m., unlicensed personnel (ULP)-H stated R1 wanted to dress themselves, but someone must help R1 with dressing because of R1's leg. ULP-H stated R1 received services for medication administration, laundry, housekeeping, and meal preparation. ULP-H also stated R1 goes out to smoke so many times and needed to be supervised by someone. R2 R2 was admitted to the licensee on July 24, 2025, with diagnoses that included schizoaffective disorder, paranoid type schizophrenia chronic state, diabetes mellitus, mixed hyperlipidemia, and tobacco dependence. R2's Support Plan effective July 1, 2026, through June 30, 2027, indicated the licensee was receiving reimbursement for the following services for R2: - homemaking; - shopping; - assistance making appointments; - three meals and two snacks; - socialization individual staff ratio 1:1; - socialization individual staff ratio 1:1 to 5; - driver and mileage for non-medical transportation; - dressing; - grooming; - bathing; - medication assistance including, verbal or visual medication reminders, medication set ups, and monitoring; and - behavior management including orientation	01640		

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01640	Continued From page 23 issues, anxiety, agitation, and self-injurious behavior. R2's service plan signed and dated July 24, 2025, indicated R2 received assistance with: - medications reminders, administration, and set up pill boxes; - treatments including weights, vital signs daily or weekly, CPAP, blood glucose checks, wound care, nebulizers, creams, and insulin; - bathing; - hygiene / grooming- assist with hair care, oral hygiene, am/pm assist with cares and grooming; - dressing; - continence; - personal laundry and housekeeping; - congregate meal; - transportation; - socialization; - managing orientation; - manage agitation; - managing self-injurious behaviors; and - manage anxiety. R2's service plan did not include following support plan services: - shopping; - driver and mileage for non-medical transportation; - appointment making; and - transportation. R2's Resident Care Report generated on September 1, 2026, for the month of August 2026, indicated R2 received the following documented services: - a.m., routine assistance; - appointment reminders; - safety assistance; - food preparation;	01640		

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01640	Continued From page 24 - activities reminder; - medication assistance; - isolation; - fix resident's bed; - p.m., routine assistance; and - personal laundry assistance. R2's Resident Care Report did not include the following service plan items which were identified in the service plan; - treatments including weights, vital signs daily or weekly, CPAP, blood glucose checks, wound care, nebulizers, creams, and insulin; - bathing; - hygiene / grooming- assist with hair care, oral hygiene, am/pm assist with cares and grooming; - dressing; - continence; - transportation; - socialization; - managing orientation; - manage agitation; - managing self-injurious behaviors; and - manage anxiety. On September 2, 2026, at approximately 2:20 p.m., ULP-H stated they managed R2's behaviors by asking the resident if they wanted to do activities when they get agitated and if R2 agreed to do activities they do it together, if not R2 would play video games to calm down. ULP-H stated they charted the behavior management under observation section daily. ULP-H stated they did not do bathing, grooming, and dressing; R2 could do those for themselves. On September 3, 2026, at 12:33 p.m., R2 stated the ULPs provide cleaning services, laundry and medication administration services. R2 stated they did not help with dressing, bathing, and	01640		

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01640	Continued From page 25 grooming, R2 stated they did all of those by themselves. R4 R4 was admitted to the licensee on April 1, 2016, with diagnoses that included diabetes mellitus type two, cerebral artery occlusion with cerebral infraction, cerebrovascular disease, and moderate recurring major depression. R4's Support Plan effective May 1, 2026, through April 30, 2027, indicated the licensee was receiving reimbursement for the following services for R4: - homemaking (housekeeping and laundry); - shopping; - assistance making appointments; - arranging non-medical transportation; - three meals and two snacks; - socialization individual staff ratio 1:1; - socialization individual staff ratio 1:1 to 5; - driver and mileage for non-medical transportation; - dressing; - bathing; - continence care; - wheeling; - assistance with self-administration of medication; medication setups and monitoring; verbal and visual medication reminders; - other delegated tasks; and - behavior management including orientation issues, anxiety, repetitive behavior, agitation, self-injurious behavior; and verbal aggression. R4's service plan signed and dated April 12, 2024, indicated R4 received assistance with: - assistance with dressing; - assistance with oral hygiene; - assistance with haircare;	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	10641 JAMES ROAD BLOOMINGTON, MN 55431

(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
01640	Continued From page 26 - assistance with grooming; - assistance with toileting; - assistance with bathing; - standby assistance; - medication administration; - hands-on assistance transfer and mobility; - personal laundry and housekeeping; and - safety check. R4's service plan did not include following support plan services: - shopping; - continence care; - assistance making appointments; - arranging non-medical transportation; - three meals and two snacks; - socialization individual staff ratio 1:1; - socialization individual staff ratio 1:1 to 5; - driver and mileage for non-medical transportation; - behavior management including orientation issues, anxiety, repetitive behavior, agitation, self-injurious behavior; and verbal aggression. R4's Resident Care Report generated on September 2, 2026, for the month of August 2026, indicated R4 received the following documented services: - appointment reminders; - food preparation; - dressing assistance; - grooming minimal assistance; - meals reminders; - medication assistance; - oral care semi independent/limited assist; - housekeeping; - bathing reminders; - BM (bowel movement) tracking; - a.m., routine assistance; - emotional health assistance;	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	10641 JAMES ROAD BLOOMINGTON, MN 55431

(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
01640	Continued From page 27 - grooming reminders; - activities reminders; - safety assistance; - p.m., routine assistance; - commode cleaning and - personal laundry assistance. R4's Resident Care Report did not include the following service plan items which were identified in the service plan; - standby assistance; and - hands-on assistance transfer and mobility. On September 2, 2026, at approximately 2:20 p.m., ULP-H stated R4 needed assistance with almost everything including toileting. R5 R5 was admitted to the licensee on August 19, 2019, with diagnoses that included diabetes mellitus type two and end stage renal disease R5's Support Plan effective August 1, 2026, through July 31, 2027, indicated the licensee was receiving reimbursement for the following services for R5: - homemaking (housekeeping and laundry); - shopping; - three meals and two snacks; - socialization individual staff ratio 1:1; - socialization individual staff ratio 1:1 to 5; - driver and mileage for non-medical transportation; - dressing; - bathing; - walking; - assistance with self-administration of medication; verbal and visual medication reminders; - insulin injection;	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	10641 JAMES ROAD BLOOMINGTON, MN 55431

(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
01640	Continued From page 28 - other delegated tasks; and - behavior management including anxiety, agitation, and verbal aggression. R5's service plan signed and dated May 12, 2026, indicated R5 received assistance with: - medications reminders, administration and set up pill boxes; - treatments including weights, vital signs daily or weekly, CPAP, blood glucose checks, wound care, nebulizers, creams, and insulin; - bathing; - hygiene / grooming- assist with hair care, oral hygiene, am/pm assist with cares and grooming; - dressing; - personal laundry and housekeeping; - congregate meal; - positioning and transfer assist; - transportation; - socialization; - delegated clinical monitoring; - vital signs; - blood sugar checks; - wound care - insulin administration; - anticoagulant monitoring of apixaban 5mg; - respiratory status / asthma action plan; - fall precautions; - infection prevention immunocompromised host; and - manage agitation. R5's service plan did not include the following support plan services: - socialization individual staff ratio 1:1; - socialization individual staff ratio 1:1 to 5; - driver and mileage for non-medical transportation; and - behavior management including anxiety, and verbal aggression.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	10641 JAMES ROAD BLOOMINGTON, MN 55431

(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
01640	Continued From page 29 R5's Resident Care Report generated on September 1, 2026, for the month of August 2026, indicated R5 received the following documented services: - a.m., routine assistance; - appointment reminders; - compression socks; - medication reminders; - oral care reminders - safety assistance; - activities reminders; - housekeeping; - personal laundry assistance; and - p.m., routine assistance. R5's Resident Care Report did not include the following items which were identified in the service plan; - bathing; - dressing; - positioning and transfer assist; - transportation; - socialization; - infection prevention immunocompromised host; and - manage agitation. On September 2, 2026, at approximately 2:20 p.m., ULP-H stated they assisted R5 with dressing, toileting, bathing, medication, and meal preparation. ULP-H stated R5 needed a little more help after R5's recent hospitalization. R6 R6 was admitted to the licensee on June 14, 2025, with diagnoses that included chronic kidney disease and left systolic heart failure. R6's Support Plan effective April 1, 2026, through	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	10641 JAMES ROAD BLOOMINGTON, MN 55431

(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
01640	Continued From page 30 March 31, 2027, indicated the licensee was receiving reimbursement for the following services for R6: - homemaking (housekeeping and laundry); - shopping; - three meals and two snacks; - finances; - socialization individual staff ratio 1:1; - driver and mileage for non-medical transportation; - dressing; - bathing; - eating nutrition consumption; - toileting; and - medication administration or assistance with self-administration, medication set ups, and monitoring. R6's service plan signed and dated June 15, 2025, indicated R6 received assistance with: - assistance with dressing; - assistance with bathing; - personal laundry; - housekeeping and linen change; - "I am ok" check service; - treatments and exercise; - prepare modified diets; - medications reminders; and - treatments and therapies. R6's service plan did not include the following support plan services: - shopping; - finances; - socialization individual staff ratio 1:1; - driver and mileage for non-medical transportation; and - toileting. R6's Resident Care Report generated on	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 31 September 1, 2026, for the month of August 2026, indicated R6 received the following documented services: - dressing; - safety assistance; - food preparation; - bathing- moderate assistance; - medication administration; - anger agitation; and - personal laundry assistance. On September 2, 2026, at approximately 2:00 p.m., clinical nurse supervisor (CNS)-C stated R2 was independent and they did not provide hygiene / grooming, assist with hair care, oral hygiene, am/pm assist with cares and grooming, dressing, or continence to R2. CNS-C stated they did manage behaviors during safety checks, but they did not have documentation for managing behaviors. CNS-C stated they did not write the Support Plan, so they could not speak to the Support Plan; CNS-C stated if the support plan indicates a resident is getting services for bathing, grooming, and dressing, it means that the resident might be getting reminders for bathing, grooming, and dressing versus hands-on assistance. CNS-C stated the reason why the service plan does not match with the service provided for all residents was because the electronic medical record (EMR) system they use must be customized. CNS-C stated they were working with the EMR system company to get it customized. On September 2, 2026, at approximately 2:20 p.m., ULP-H stated R6 did dress and bathe themself; ULP-H stated R6 did not need a bathing reminder and stated R6 sometimes showered four times a day. ULP-H also stated R6 had used commode in the past but did not any longer.	01640		

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	32061	A. BUILDING: _____ B. WING _____	09/03/2026

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RESIDENTIAL CARE NINE MILE CRK	10641 JAMES ROAD BLOOMINGTON, MN 55431

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01640	Continued From page 32 ULP-H stated R6 received assistance with medication administration, laundry, meal preparation, and housekeeping. On September 3, 2026, at 11:30 a.m., owner (O)-E stated they have two ULPs working to cover 1:1 socialization for residents who needed 1:1. O-E stated they did not have behavior management listed on the service plan for some of the residents but they had been managing behaviors for residents. The surveyor inquired how the licensee would prove residents have been getting the services since there was no documentation. O-E stated, "you can see it with your own eyes"; O-E stated this was new thing; they have never been asked about the support plan and the service plan before. O-E further stated, "I know we are supposed to be charting, and we will take this as an opportunity to learn." On September 3, 2026, at 11:50 a.m., O-E stated they are charging 0.1 units for dressing and bathing for R1, that could be for telling R1 to take a bath and lay out his clothes for him. O-E stated it was the same for all residents, whatever they are billing should match with what they are providing and charting. O-E stated, "This is a learning experience for us, we will get better." The licensee's 6.08 Service Plan policy dated June 30, 2021, indicated all residents who received assisted living services would have a service plan in place. Service plans were based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. A service plan was the written plan between a resident or a resident's designated representative and the facility about the services that would be provided to the resident. The	01640		

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01640	Continued From page 33 service plan and any revisions shall include a signature or other authentication by the licensee and by the residents or resident's representative documenting agreement on the services to be provided. In addition, the service plan would include a description of the services that were to be provided based on the most recent assessment and resident preference and would include the frequency of the service, and the fee for service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with a consumer bed rail. This resulted in an immediate correction order on August 31, 2026. 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	02310		

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02310	Continued From page 34 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 August 31, 2026, at approximately 12:00 p.m., during a facility tour, the surveyor observed an inverted U-shaped black consumer bed rail adjacent to the right side of R1's bed. The surveyor observed the bed rail was not attached to the bed. The surveyor observed, without difficulty, owner (O)-E pulled the bed rail out from underneath the mattress and pushed it back in. R1 was admitted to the licensee on March 12, 2026, with diagnoses that included schizophrenia and traumatic brain injury. R1's Service Plan with effective date of March 26, 2026, indicated R1 received services for, dressing, continence care, meal assistance, and socialization. R1's most recent 90-day assessment completed on June 23, 2026, indicated no devices were used for bed mobility for R1. R1's record lacked assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition to include: - purpose and intention of the bed rail; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks);	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

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02310	Continued From page 35 - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; - individualized bed rail assessment to assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls; - consideration whether the bed rail has the effect of being an improper restraint; - consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc.; and - check of the Consumer Product Safety Commission (CPSC) website for the most up-to-date information related to portable bed side rail recall information. On August 31, 2026, at approximately 12:00 p.m., the owner (O)-E stated they did not consider R1's consumer bed rail as a bed rail and stated it is just a device R1 uses for getting in and out of bed. On August 31, 2026, at 12:10 p.m., clinical nurse supervisor (CNS)-C stated the device on R1's bed was not a bed rail, it a thing that R1 uses to in and out of bed. CNS-C stated they did not consider the device as bed rail and there was no assessment completed for the bed rail. CNS-C stated movers helped R1 install the bed rail when R1 moved in. CNS-C stated they did not have the manufacturer's guideline or the name, make, or model of the bed rail.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 36 On August 31, 2026, at approximately 3:35 p.m., surveyors observed R1's inverted U-shaped bed rail opening measured approximately 12 inches wide with the length from the mattress to the top of the bed rail approximately 12 inches. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." Additionally, the FAQ indicated documentation of a bed rail should include but is not limited to: - purpose and intention of the bed rail; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; - individualized bed rail assessment to assess the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32061	A. BUILDING: _____ B. WING _____	09/03/2026

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02310	Continued From page 37 individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls; - consideration whether the bed rail has the effect of being an improper restraint; and - consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc.; and - licensee's should refer to the Consumer Product Safety Commission (CPSC) website for the most up-to-date information related to portable bed side rail recall information. The licensee's 6.28 Siderail policy dated June 30, 2120 [sic] indicated, POLICY: When the licensee is aware a home care resident is utilizing side rails (a medical device) on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

RESIDENTIAL CARE NINE MILE CRK
10641 James Rd
Bloomington, MN 55431
Hennepin County
Parcel:

Phone:

License Info

License: HFID 32061

Risk:
License:
Expires on:
CFPM: Safia Omar
CFPM #: 53359; Exp: 10/2/2027

Inspection Info

Report Number: F1013261058
Inspection Type: Full - Single
Date: 8/31/2026 Time: 01:00 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator D. Mosissa.

The establishment has a residential kitchen and serves food prepared on the same day. The kitchen has wood cabinets, wood floor, laminate walls, laminate counter top, and a textured ceiling.

A two basin sink is located in the kitchen. A separate designated hand washing sink is located in the kitchen.

Residential dish machine is available to wash ware. The dish machine should be run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

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 F1013261058 from 8/31/2026

Jerry Malloy

Safia Omar
Operator

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

RESIDENTIAL CARE NINE MILE CRK
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1013261058
Inspection Type: Full
Date: 8/31/2026
Time: 01:00 pm

Food Temperature: Product/Item/Unit: Sliced melon**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Fries**; Temperature Process:** Cold-Holding
Location: Freezer at 12 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Waffles**; Temperature Process:** Cold-Holding
Location: Basement freezer at 15 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

RESIDENTIAL CARE NINE MILE CRK
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1013261058
Inspection Type: Full
Date: 8/31/2026
Time: 01:00 pm

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL32061016-0	**Date:** August 31, 2026
Facility Name: RESIDENTIAL CARE NINE MILE CRK	
Facility Address: 10641 JAMES RD, Bloomington, MN, 55431	

☒ **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 employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

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

   Comments: Owner (O)-E and house manager (HM)-F provided staff training records from a web-based training site the training documentation record lacked any training on the facility-specific FSEP.