Electronically Delivered

October 21, 2026

Licensee
Goodness And Mercy Health Services, Inc.
5101 63rd Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL32692016

Dear Licensee:

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

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

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

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

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

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

**0340 - 144g.30 Subd. 5 - Correction Orders - $500.00**

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

**DOCUMENTATION OF ACTION TO COMPLY**
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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,

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

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32692 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOODNESS AND MERCY HEALTH SERVICES, | 5101 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL32692016-0<br><br>On September 21, 2026, through September 23, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four (4) residents; all of whom received services under the Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 320 SS=E | 144G.30 Subdivision 1 Regulatory powers<br><br>(a) The Department of Health is the exclusive | 0 320 | | |

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| 0 320 | Continued From page 1<br><br>state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter.<br>(b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide requested necessary resident record and failed to provide documentation of actions taken to comply with the correction orders from a survey completed August 21, 2024, in a timely manner to determine compliance with licensure laws and rules.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). | 0 320 | | |

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| 0 320 | Continued From page 2<br><br>The findings include:<br><br>RESIDENT RECORD<br>On September 21, 2026, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were responsible for developing and maintaining the residents' service plans. LALD/CNS-A also stated their current census was four (4) residents.<br><br>On September 21, 2026, at 1:49 p.m., via email, the surveyor requested signed service plans for all residents.<br><br>On September 22, 2026, at 10:01 a.m., via email to operations manager/registered nurse (OM/RN)-C and administrator/RN (A/RN)-D, the surveyor requested the remaining service plans as requested (including R4's service plan) by 11:00 a.m., same day.<br><br>On September 23, 2026, at 1:45 p.m., in person, the surveyor asked A/RN-D for R4's service plan again because it was not provided the day prior.<br><br>During exit conference with OM/RN-C and A/RN-D on September 23, 2026, at 2:15 p.m., the surveyor requested R4's service plan for the fourth time which they both said they would provide. The surveyor never received R4's service plan.<br><br>PLAN OF CORRECTION<br>On September 21, 2026, at 12:15 p.m., the surveyor requested the licensee's documented plan of correction for the previous survey. LALD/CNS-A stated they had one to provide. | 0 320 | | |

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| 0 320 | Continued From page 3<br><br>On September 22, 2026, at 10:01 a.m. via email to OM/RN-C and A/RN-D, the surveyor indicated they were still waiting for the documented plan of correction for the previous survey. The surveyor requested the plan by 11:00 a.m., same day.<br><br>On September 22, 2026, at 3:32 p.m., via email to OM/RN-C and A/RN-D, the surveyor indicated they still had not received the requested plan of correction documenting actions taken and requested it the following day.<br><br>On September 23, 2026, at 12:54 p.m. (two full days since initial request), the surveyor finally received the plan of correction after multiple requests.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 320 | | |
| 0 340 SS=F | 144G.30 Subd. 5 Correction orders<br><br>(a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.<br>(b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public | 0 340 | | |

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| 0 340 | Continued From page 4<br><br>documents shall be made available for viewing by any person upon request. Copies may be kept electronically.<br>(c) By the correction order date, the facility must:<br>(1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed August 21, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee.<br><br>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).<br><br>The findings include:<br><br>The licensee received their correction orders via electronic delivery on September 20, 2024, following their August 21, 2024, survey. The longest period for correction on the correction orders from the date of receipt was 21 days | 0 340 | | |

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| 0 340 | Continued From page 5<br><br>On September 21, 2026, through September 23, 2026, the Minnesota Department of Health conducted a routine survey and re-issued correction order related to background studies (BGS).<br><br>On September 21, 2026, at 12:15 p.m., the surveyor requested the plan of correction (POC) for the correction orders from the previous survey. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had one to provide.<br><br>On September 22, 2026, at 10:01 a.m. via email to operations manager/registered nurse (OM/RN)-C and administrator/RN (A/RN)-D, the surveyor indicated they were still waiting for the completed POC for the previous survey.<br><br>On September 22, 2026, at 10:52 a.m., during BGS discussion, OM/RN-C stated they were responsible for completing BGS for all new hires. They had the same issue during the last survey and at the time they thought whenever a staff person completed a BGS they were automatically affiliated with all facilities. OM/RN-C acknowledged correction order 1290 was corrected on September 21, 2026, during this survey.<br><br>On September 22, 2026, at 3:32 p.m., via email to OM/RN-C and A/RN-D, the surveyor indicated they still had not received the requested POC documenting actions taken.<br><br>On September 23, 2026, at 12:54 p.m., the surveyor finally received the POC after multiple requests. The licensee's POC lacked documentation of actions taken to comply with the correction order for 1290. | 0 340 | | |

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| 0 340 | Continued From page 6<br><br>The Minnesota Department of Health (MDH) Correction Order Documentation Guidelines, dated June 30, 2021, indicated correction order documentation should include the following:<br>-identify how each order was corrected related to each individual resident(s)/employee(s) identified in the order;<br>-identify how each order was corrected for all the provider's resident(s)/employee(s) identified in the order; and<br>-identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 340 | | |
| 0 345 SS=C | 144G.30 Subd. 5. (c)(2), (d) Correction orders<br><br>(c)(2) make available, in a manner readily accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order.<br>(d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another | 0 345 | | |

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| 0 345 | Continued From page 7<br>format, including a paper copy, upon request.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to make available the most recent plan of correction (POC) in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders issued for the licensee's survey completed August 21, 2024.<br><br>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at 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).<br><br>The findings include:<br><br>On September 21, 2026, at 12:15 p.m., the Minnesota Department of Health (MDH) surveyor requested documentation of the licensee's POC related to the citations issued after the previous survey completed on August 21, 2024. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had one to provide.<br><br>On September 21, 2026, at 2:00 p.m., the surveyor asked what the licensee did to get their emergency preparedness plan ((EPP)-correction order 0680) corrected after the last survey. LALD/CNS-A stated they got templates on missing content from Care Providers (consultant) to include in their EPP but they received those forms recently and were going through it to | 0 345 | | |

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| 0 345 | Continued From page 8<br><br>update it. LALD/CNS-A also stated when the EPP binder was brought back to the office, a lot of forms fell out so it did not include all missing content.<br><br>On September 23, 2026, at 12:54 p.m., the surveyor finally received their POC after multiple requests. The POC included documents and policies related to the licensee's emergency preparedness plan (0680), documentation of actions made to correct 0800 and 0820, a completed individualized medication management plan for R1 dated September 2, 2024 (1730), and documentation of actions made to correct 1890.<br><br>The licensee's POC lacked documentation of actions taken to comply with correction orders 0810, 0910, 0950, 1060, 1290, 1620, and 1730.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 345 | | |
| 0 450 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>All assisted living facilities shall:<br>(1) distribute to residents the assisted living bill of rights;<br>(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;<br>(3) utilize a person-centered planning and service delivery process;<br>(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required | 0 450 | | |

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| 0 450 | Continued From page 9<br>by the Nurse Practice Act in sections 148.171 to 148.285;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure utilization of person-centered planning and service delivery process for each resident receiving services. This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1<br>R1 was admitted for services on January 19, 2017, and began receiving assisted living services on August 1, 2021.<br><br>R1 had diagnoses including cognitive impairment, diabetes, schizophrenia, and mild mental retardation.<br><br>R1's unsigned Service Plan (Waiver) - Addendum to Contract dated July 19, 2024, indicated R1 received services such as medication administration, bathing assistance, manage behavior-physical aggression, resistive tendencies, and social inappropriateness three (3) times per day, safety checks 12 times per day, recording bowel movement (BM) three (3) times | 0 450 | | |

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| 0 450 | Continued From page 10<br>per day, and laundry.<br><br>R1 Clinical Update Summary (nursing assessment) dated July 13, 2026, indicated R1 was well hydrated, at no risk for dehydration, and independent with fluid consumption. R1 was also independent with toileting and able to make needs and wants known with single syllable words. R1 also denied active digestion problems.<br><br>R1's medication administration record (MAR) dated August and September 2026, indicated R1 did not receive any medications as needed for gastrointestinal symptoms.<br><br>R3<br>R3 was admitted for services on June 26, 2017, and began receiving assisted living services on August 1, 2021.<br><br>R3 had diagnoses including schizophrenia, diabetes, gastro-esophageal reflux, and obesity.<br><br>R3's unsigned Service Plan (Waiver) - Addendum to Contract dated September 22, 2026, indicated R3 received services such as medication administration four (4) times daily, bathing assistance two (2) days per week, manage behavior-physical aggression, resistive tendencies, and verbal aggression three (3) times per day, safety checks 12 times per day, recording bowel movement (BM) three (3) times per day, and laundry.<br><br>R3's Clinical Update Summary dated July 13, 2026, indicated R3 was well hydrated and took adequate fluids but refused fruits and vegetables. R3 was independent with toileting, and no current signs or symptoms of gastrointestinal issues were reported. | 0 450 | | |

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| 0 450 | Continued From page 11<br><br>On September 21 and 22, 2026, at lunchtime, the surveyor observed both R1 and R3 eat lunch independently at the dining room table.<br><br>On September 22, 2026, at 2:00 p.m., unlicensed personnel (ULP)-B stated she would ask all residents if they had a bowel movement. She stated R2 would come to ULP-B to inform ULP-B of his results. ULP-B stated she would chart number of times each resident had a bowel movement during her shift.<br><br>On September 23, 2026, at 1:45 p.m., administrator/registered nurse (A/RN)-D stated all residents received bowel monitoring because it was a "company order, and what if they had a bowel obstruction (partial or complete blockage of small or large intestine)?" The surveyor asked if a resident had issues or history of constipation or obstruction, A/RN-D stated no, but said it was "good nursing care." A/RN-D stated all residents could tell staff if they felt constipated but stated some residents may not tell staff.<br><br>The Minnesota Bill of Rights for Assisted Living dated January 1, 2026, indicated 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.<br><br>The licensee's Service Plan policy effective August 1, 2021, indicated that all residents receiving assisted living services would have a service plan in place. Service plans are based on the agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. | 0 450 | | |

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| 0 450 | Continued From page 12<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 450 | | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;<br>(4) notwithstanding Minnesota Rules, part | 0 480 | | |

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| 0 480 | Continued From page 13<br><br>4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include: | 0 480 | | |

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| 0 480 | Continued From page 14<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 22, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 650 SS=F | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced | 0 650 | | |

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| 0 650 | Continued From page 15<br>by:<br>Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (operations manager/registered nurse (OM/RN)-C, unlicensed personnel (ULP)-B, ULP-J).<br><br>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).<br><br>The findings include:<br><br>During entrance conference on September 21, 2026, at 10:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the required contents of the employee records.<br><br>OM/RN-C and ULP-B were hired on April 20, 2006, and September 8, 2008, respectively, and began providing assisted living (AL) services on August 1, 2021.<br><br>ULP-J was hired on March 3, 2026, to provide assisted living services.<br><br>DOCUMENTATION OF ORIENTATION<br>OM/RN-C and ULP-B's AL 2021 Initial Training indicated they both completed the following training:<br>-orientation to assisted living (several topics) completed between August 2 through August 4, | 0 650 | | |

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| 0 650 | Continued From page 16<br><br>2021;<br>-infection control and tuberculosis education on August 4, 2021;<br>-initial eight (8) hours of dementia care training on August 16, 2021; and<br>-initial two (2) hours of mental illness and de-escalation training on August 18, 2021.<br><br>The training document indicated competency was demonstrated for dementia and mental illness using knowledge tests and orientation training was provided by LALD/CNS-A (name and title were typed). OM/RN-C and ULP-B both lacked signatures attesting they both successfully completed the training as described and lacked written or electronic signature by the registered nurse and/or trainer attesting they trained OM/RN-C and ULP-B on the above topics.<br><br>DOCUMENTATION OF ANNUAL TRAINING<br>OM/RN-C and ULP-B's GMHS AL Annual Trainings form indicated they completed majority of the required annual training June of 2024, June of 2025, and June of 2026 (ULP-B completed 2026 training on a different training program). The training record lacked the following required information:<br>- training methodology, such as classroom style, web-based training, video, or one-to-one training;<br>- name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and<br>- name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described | 0 650 | | |

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| 0 650 | Continued From page 17<br>in the training documentation.<br><br>On September 22, 2026, at 2:50 p.m., OM/RN-C stated LALD/CNS-A provided one-on-one training for each person for the initial 2021 training and annual training, then they started using Educare (an online training platform) this year. OM/RN-C stated there was an "attestation form for the 2024 and 2025 annual training" but would need to retrieve it from the office. The attestation form was never provided.<br><br>DOCUMENTATION OF COMPETENCIES<br>On September 22, 2026, at 12:05 p.m., the surveyor observed ULP-B administer oral and eye drop medication to R3.<br><br>ULP-B<br>ULP-B's record lacked documentation of ULP-B demonstrating competency performing the following delegated tasks:<br>-administering medication (all routes) and treatments (blood glucose monitoring); and<br>-preparing medications for unplanned times away.<br><br>ULP-J<br>ULP-J's GMHS Staff Training and Competency Record Course List indicated ULP-J demonstrated the following to LALD/CNS-A (signed and dated March 5, 2026):<br>-blood glucose monitoring (did not indicate specific type of monitoring system);<br>-medication administration (did not specify which routes were demonstrated); and<br>-treatment administration (did not specify which treatments were observed).<br><br>ULP-J's Practical Skills Test and Competency signed by LALD/CNS-A on May 25, 2026 | 0 650 | | |

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| 0 650 | Continued From page 18<br><br>(approximately 81 days from above competency), indicated ULP-J was competent on oral and eye medication administration, administering treatments (indicated oral and eye which are not treatments), and blood glucose treatment (did not indicate specific type of monitoring system).<br><br>On September 22, 2026, at 10:30 a.m., ULP-B stated she received annual training June of this year on Educare for topics such as infection control, vulnerable adult, bill of rights, and received emergency preparedness training in person during meetings. ULP-B was unable to recall the initial 2021 training since it "was so long ago."<br><br>On September 23, 2026, at 11:50 a.m., LALD/CNS-A explained he had provided one-on-one training for each staff person and referenced the training binder in front of him. LALD/CNS-A stated he had staff do return demonstrations on medication administration, but he did not document what was specifically observed at that time for anyone. OM/RN-C stated she knew which medication administration routes staff were checked off based on the medication routes residents had at the time. The surveyor requested ULP-B's knowledge checks (for dementia and mental illness) LALD/CNS-A stated he had them.<br><br>On September 23, 2026, at 12:45 p.m., LALD/CNS-A returned to the facility and provided the surveyor with a dementia quiz example they used but he did not provide ULP-B's knowledge checks as requested.<br><br>The licensee's Staff Competency policy effective August 1, 2021, indicated the CNS was responsible for training and competency | 0 650 | | |

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| 0 650 | Continued From page 19<br><br>evaluation of the ULP by completing a practical skills test on administration of medications and treatment. The policy also indicated the following documentation would be maintained related to competency evaluations:<br>a. Facility name<br>b. Name of topic and methodology<br>c. Date and total time<br>d. Name/title of instructor and evaluator<br>e. Name/title of staff person completing the competency evaluation.<br><br>The licensee's Staff Orientation and Education policy effective August 1, 2021, indicated the orientation checklist would be used to document and verify the completion of orientation for each employee. Upon completion of the orientation, the signed/dated Orientation Checklist would be retained in the employee record.<br><br>Minnesota Administrative Rule 4659.0190, subpart 6, A., dated August 11, 2021, indicated the facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic:<br>- facility name, location, and license number;<br>- name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training;<br>- date of the training and competency evaluation, and the total amount of time of the training and competency evaluation;<br>- name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a | 0 650 | | |

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| 0 650 | Continued From page 20<br><br>statement attesting that the employee successfully completed the training and competency evaluation; and<br>- name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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 | 0 680 | | |

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| 0 680 | Continued From page 21<br><br>working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post the EPP prominently. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On September 21, 2026, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided two binders, one all-white in color titled "Emergency Preparedness Manual" with one address crossed out and another address handwritten on it (neither address was for this facility), and all-black binder titled "Emergency Preparedness Manual" with facility address. LALD/CNS-A stated they were in the middle of updating and condensing the two binders and said to refer to both binders for the EPP content.<br><br>The licensee's EPP, dated August 2, 2024, lacked the following required content: | 0 680 | | |

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| 0 680 | Continued From page 22<br><br>-establishment of the emergency program (not customized to facility-including multiple facilities);<br>-develop and maintain an EPP (no documentation of annual review/update and no hazard vulnerability assessment available for this facility);<br>- maintain and annual EPP updates;<br>-missing resident plan reviewed quarterly;<br>-resident population;<br>-process for emergency preparedness collaboration;<br>-development of policies and procedures;<br>-policies and procedures for subsistence needs for staff and residents;<br>-policies and procedures for tracking staff and residents;<br>-policies and procedures including evacuation;<br>-policies and procedures for sheltering in place;<br>-policies and procedures for medical documents;<br>-policies and procedures for volunteers;<br>-policies and procedures for arrangements with other facilities;<br>-policies and procedures for roles under a waiver declared by secretary;<br>-communication plan-names and contact information;<br>-communication plan-emergency officials contact information (lacked local, regional, and tribal contact information);<br>-communication plan-methods for sharing information;<br>-communication plan-procedure for sharing information on occupancy and/or needs;<br>-communication plan-long term care family notifications; and<br>-emergency prep testing requirements.<br><br>On September 21, 2026, at 2:00 p.m., LALD/CNS-A stated they were responsible for maintaining the EPP. LALD/CNS-A stated they reviewed the EPP and missing resident plan | 0 680 | | |

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| 0 680 | Continued From page 23<br><br>typically once a year when they have a meeting but did not document the review. LALD/CNS-A was not aware the missing resident plan needed to be reviewed quarterly and their plan of action to get their EPP into compliance from the previous survey was obtaining the missing content from Care Providers (provides education and consulting services). LALD/CNS-A stated they completed drills and training and went over scenarios with staff. He stated he would provide documentation via email. They were not provided prior to survey completion. When asked why the EPP binder was not posted prominently for the surveyor to locate, LALD/CNS-A explained he had the EPP binders at the office because they had obtained forms recently and were updating it and while at the office, LALD/CNS-A stated "a lot of things fell out" and what they had provided was what was available at the moment.<br><br>The licensee's Emergency Preparedness policy effective August 1, 2021, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy also indicated the EPP would be prominently posted and reviewed/updated at least annually.<br><br>The licensee's Missing Resident policy effective August 1, 2021, indicated the licensee would review and document the missing resident procedure at least quarterly.<br><br>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. | 0 680 | | |

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| 0 680 | Continued From page 24<br><br>This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 790 SS=A | 144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one | 0 790 | | |

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| 0 790 | Continued From page 25<br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 790 | | |
| 0 800 SS=A | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>This practice resulted in a level one violation (a violation that will cause only minimal impact on | 0 800 | | |

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| 0 800 | Continued From page 26<br><br>the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 800 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for one of one resident (R1).<br><br>This practice resulted in a level one violation (a | 0 970 | | |

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| 0 970 | Continued From page 27<br><br>violation that will cause only 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).<br><br>The findings include:<br><br>On September 22, 2026, at 8:50 a.m., administrator/registered nurse (A/RN)-D provided R1's contract and stated the contract was used for all residents and they were signed annually.<br><br>R1 was admitted for services on January 19, 2017, and began receiving assisted living services on August 1, 2021.<br><br>On September 22, 2026, at 12:18 p.m., the surveyor observed unlicensed personnel (ULP)-B administer eye drops to R1.<br><br>R1's Assisted Living Contract electronically signed on January 10, 2026, included the following language waving the licensee's liability for health, safety, or personal property of a resident:<br>-Miscellaneous Provisions 1. Insurance Liability and Release. "The resident acknowledges that [licensee name] is not an insurer of the resident's person or property. The resident agrees that [licensee name] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident .... unless and to the extent that the injury or damage is caused by the negligence of [licensee name] or its employees or agents. The resident hereby releases [licensee name] from liability for any | 0 970 | | |

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| 0 970 | Continued From page 28<br><br>personal injury or property damage suffered by the resident .... unless caused by the negligence of [licensee name] or its employees or agents."<br><br>On September 22, 2026, at 10:52 a.m., operations manager/RN (OM/RN)-C stated at their last survey, the surveyor indicated they had a waiver of liability, and they thought they had removed it. OM/RN-C was shown where the contract contained a waiver of liability and stated they would get that removed.<br><br>The licensee's Notifications policy effective August 1, 2021, indicated prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01290 SS=F | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith | 01290 | | |

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| 01290 | Continued From page 29<br><br>reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for six of eleven employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G, ULP-H, ULP-I).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On September 21, 2026, at 11:23 a.m., via email, the surveyor requested the NETStudy 2.0 Roster (web-based system used to submit BGS requests to the Department of Human Services (DHS)). At 3:00 p.m., the surveyor received the NETStudy 2.0 Roster from the licensee but due to the format of the document, it did not provide all the required information, so the surveyor received one from their supervisor.<br><br>ULP-B, ULP-E, ULP-F, ULP-G, and ULP-H were hired to provide services on September 8, 2008, | 01290 | | |

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| 01290 | Continued From page 30<br><br>May 25, 2007, January 23, 2018, February 26, 2019, and June 21, 2019, respectively, and all began providing assisted living services on August 1, 2021.<br><br>ULP-I was not listed on the employee roster nor staff schedule dated September 21, 2026, through October 4, 2026.<br><br>R1's medication administration record (MAR) dated September 2026, included ULP-I's initials "ooj" indicating ULP-I administered medications to R1 at 12:00 p.m., 4:00 p.m., 5:00 p.m., and 8:00 p.m., on September 4, and September 18, 2026, indicating they were in contact with residents.<br><br>On September 22, 2026, at 10:30 a.m., the surveyor observed ULP-B and ULP-E working, where ULP-B remained at the facility and ULP-E ran errands and took residents on outings. ULP-E stated they were the supervisor.<br><br>ULP-B, ULP-E, ULP-F, ULP-G, ULP-H, and ULP-I's record lacked a cleared DHS background study affiliated with the licensee prior to September 21, 2026 (corrected during the survey). They were affiliated with licensee's sister facilities or licenses through DHS.<br><br>On September 22, 2026, at 10:52 a.m., operations manager/registered nurse (OM/RN)-C stated they were responsible for completing BGS for all new hires. They had this issue during the last survey (about two years ago) and at the time they thought whenever a staff person completed a BGS they were automatically affiliated all facilities owned by the same owner. OM/RN-C stated they began using a new hire checklist reminding them to affiliate a new hire to each | 01290 | | |

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| 01290 | Continued From page 31<br>facility.<br><br>The licensee's Recruitment and Hiring policy effective August 1, 2021, indicated the administrator or designee was responsible for initiating the criminal background study for new employees and NETStudy 2.0 would be used for the background check. The policy lacked affiliation procedures.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 01290 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(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.<br>(c) Resident reassessment and monitoring must be conducted by a registered nurse:<br>(1) no more than 14 calendar days after initiation | 01620 | | |

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| 01620 | Continued From page 32<br>of services;<br>(2) as needed based on changes in the resident's needs; and<br>(3) at least every 90 calendar days.<br>(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.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for three of three residents (R1, R2, R3). The licensee also failed to ensure an RN conducted resident reassessment and monitoring at least every 90 calendar days for two of two residents (R1, R3). | 01620 | | |

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| 01620 | Continued From page 33<br><br>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).<br><br>The findings include:<br><br>On September 22, 2026, at 12:05 p.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1 and R3.<br><br>R1<br>R1 was admitted for services on January 19, 2017, and began receiving assisted living services on August 1, 2021.<br><br>R1 had diagnoses including cognitive impairment, diabetes, schizophrenia, and mild mental retardation.<br><br>R1's unsigned Service Plan (Waiver) - Addendum to Contract dated July 19, 2024, indicated R1 received services such as medication administration, bathing assistance, manage behavior-physical aggression, resistive tendencies, and social inappropriateness three (3) times per day, safety checks 12 times per day, recording bowel movement (BM) three (3) times per day, and laundry.<br><br>R1's nursing assessments were completed on December 15, 2025, April 14, 2026 (120 days after last assessment), and July 13, 2026, respectively, by administrator/RN (A/RN)-D. | 01620 | | |

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| 01620 | Continued From page 34<br><br>R1's nursing assessments lacked the following content of the uniform assessment tool:<br>-weight;<br>-initial vital signs if indicated by health conditions or medications;<br>-nutritional status and hydration preferences;<br>-communication and sensory capabilities including hearing, and assistive communication and sensory devices including hearing aids;<br>-list of treatments, including type, frequency, and level of assistance needed;<br>-risk for falls including history of falls; and<br>-risk for alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician.<br><br>R2<br>R2 was admitted for assisted living services on November 28, 2025, and had diagnoses including paranoid schizophrenia.<br><br>R2's Service Plan (Private) - Addendum to Contract signed November 28, 2025, indicated R2 received medication administration, behavior monitoring and management, transportation, meal preparation, medical coordination, medication management, supervision and cues with ADLs (activities of daily living), and assistance with IADLs (instrumental ADL).<br><br>R2's current nursing assessment dated July 13, 2026, lacked the following content of the uniform assessment tool:<br>-medical diagnoses;<br>-nutritional and hydration preferences; and<br>-risk for falls including history of falls.<br><br>R3<br>R3 was admitted for services on June 26, 2017, and began receiving assisted living services on | 01620 | | |

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| 01620 | Continued From page 35<br>August 1, 2021.<br><br>R3 had diagnoses including schizophrenia, diabetes, gastro-esophageal reflux, and obesity.<br><br>R3's unsigned Service Plan (Waiver) - Addendum to Contract dated September 22, 2026, indicated R3 received services such as medication administration four (4) times daily, bathing assistance two (2) days per week, manage behavior-physical aggression, resistive tendencies, and verbal aggression three (3) times per day, safety checks 12 times per day, recording bowel movement (BM) three (3) times per day, and laundry.<br><br>R3's Assessments were completed on December 15, 2025, April 14, 2026 (120 days after last assessment), and July 13, 2026, respectively, by A/RN-D.<br><br>R3's nursing assessments lacked the following content of the uniform assessment tool:<br>-weight;<br>-initial vital signs if indicated by health conditions or medications;<br>-hydration preferences;<br>-list of treatments, including type, frequency, and level of assistance needed;<br>-risk for falls including history of falls;<br>-risk for alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; and<br>-the need for follow-up referrals for additional medical or cognitive care by health professionals.<br><br>On September 22, 2026, at 11:27 a.m., the surveyor asked A/RN-D where they could locate R1 and R3's treatment assessment within their comprehensive assessment. A/RN-D stated their | 01620 | | |

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| 01620 | Continued From page 36<br><br>electronic health record (Residex) may not have had all the features but after looking at the assessments, A/RN-D was unable to locate the missing required information. A/RN-D also stated she was not aware the content of the uniform assessment tool was required for all assessments.<br><br>On September 23, 2026, at 1:45 p.m., when the surveyor asked why R1 and R3's assessments were completed beyond 90 days, A/RN-D stated she could not remember why it was late, then stated she may have completed an assessment on paper then for the next one on Residex. A/RN-D again said, "I do not remember."<br><br>The licensee's Comprehensive Nursing Assessment policy effective August 1, 2021, indicated the RN would conduct a comprehensive assessment for all residents to determine the services required and develop an individualized care plan for staff to implement. The policy also indicated the RN would conduct a comprehensive assessment utilizing a uniform assessment tool.<br><br>The licensee's Assessment and Reassessment policy effective August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment.<br><br>Minnesota Rules Chapter 4659.0140, Subp. 2, dated August 1, 2021, 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).<br>B. The nursing assessment or reassessment | 01620 | | |

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| 01620 | Continued From page 37<br><br>under item A must:<br>(1) address part 4659.0150, subpart 2, items A to N;<br>(2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies;<br>(3) be conducted using a uniform assessment tool that complies with part 4659.0150; and<br>(4) be in writing, dated, and signed by the registered nurse who conducted the assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01640 SS=E | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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.<br>(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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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. | 01640 | | |

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| 01640 | Continued From page 38<br><br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to obtain a signature or other authentication by the licensee to document agreement of services to be provided for two of three residents (R1, R3) that were receiving services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>During entrance conference on September 21, 2026, at 10:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee would go over the service plan with the residents and they sign it. If there were a change in the residents' physical needs, the service plan would be updated.<br><br>On September 21, 2026, at 1:49 p.m., via email, the surveyor requested signed service plans for all four (4) residents.<br><br>R1<br>R1 was admitted for services on January 19, 2017, and began receiving assisted living | 01640 | | |

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| 01640 | Continued From page 39<br>services on August 1, 2021.<br><br>R1's Service Plan (Waiver) - Addendum to Contract dated July 19, 2024, indicated R1 received services such as medication administration, bathing assistance, manage behavior-physical aggression, resistive tendencies, and social inappropriateness three (3) times per day, safety checks 12 times per day, recording bowel movement (BM) three (3) times per day, and laundry. R1's service plan was signed by administrator/registered nurse (A/RN)-D on July 19, 2024, but lacked a signature or other authentication by the resident or resident's representative documenting agreement on the services to be provided.<br><br>R3<br>R3 was admitted for services on June 26, 2017, and began receiving assisted living services on August 1, 2021.<br><br>R3's Service Plan (Waiver) - Addendum to Contract dated September 22, 2026, indicated R3 received services such as medication administration four (4) times daily, bathing assistance two (2) days per week, manage behavior-physical aggression, resistive tendencies, and verbal aggression three (3) times per day, safety checks 12 times per day, recording bowel movement (BM) three (3) times per day, and laundry. R3's service plan lacked a signature or other authentication by the facility and by the resident or resident's representative documenting agreement on the services to be provided.<br><br>On September 23, 2026, at 1:45 p.m., the surveyor asked A/RN-D why R3's service plan was not signed, she did not provide the surveyor | 01640 | | |

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| 01640 | Continued From page 40<br>an answer.<br><br>On September 23, 2026, at 2:15 p.m., during exit conference, A/RN-D stated R1's service plan was not signed because of R1's language barrier and indicated R1's guardian did not sign it either. The surveyor never received R4's signed or unsigned service plan as requested multiple times.<br><br>The licensee's Service Plan policy effective August 1, 2021, indicated initial service plans and any revisions are signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided. Service plans are entered into the clinical record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01650 SS=D | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided; | 01650 | | |

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| 01650 | Continued From page 41<br><br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the residents' service plan included all required content for one of three residents (R2).<br><br>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).<br><br>The findings include:<br><br>On September 21, 2026, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were responsible for developing and maintaining the residents' service plans. | 01650 | | |

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| 01650 | Continued From page 42<br><br>R2 was admitted for services on November 28, 2025, and had a diagnosis of paranoid schizophrenia.<br><br>On September 22, 2026, at 11:55 p.m., administrator/registered nurse (A/RN)-D provided R2's signed service plan which included handwritten services on a printed service plan. The surveyor asked A/RN-D to provide a complete service plan to include all required content even if it was not signed and she said she would provide it.<br><br>R2's service plan lacked the fee for services and frequency of each service.<br><br>On September 23, 2026, at 1:44 p.m., A/RN-D brought back the same service plan for R2 and again, the surveyor requested the service plan to include all required content. A/RN-D stated the copy provided was the only copy available.<br><br>The licensee's Service Plan policy effective August 1, 2021, indicated the resident's service plan would include the fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01650 | | |
| 01760 SS=F | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the | 01760 | | |

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| 01760 | Continued From page 43<br><br>resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medication orders were transcribed accurately, and medication administration was documented correctly for one of two residents (R1).<br><br>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).<br><br>The findings include:<br><br>R1 was admitted for services on January 19, 2017, and began receiving assisted living services on August 1, 2021.<br><br>R1 had diagnoses including cognitive impairment, diabetes, schizophrenia, and mild mental retardation. | 01760 | | |

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| 01760 | Continued From page 44<br><br>R1's unsigned Service Plan (Waiver) - Addendum to Contract dated July 19, 2024, indicated R1 received assistance with medication administration.<br><br>R1 Clinical Update Summary (nursing assessment) dated July 13, 2026, indicated R1 required assistance with medication administration and management. Under Medication Management, the assessment indicated the licensed nurse was responsible for monitoring medication supplies and reordering as needed. Additionally, during medication management, staff were to inform the nurse face to face and via text messaging if questions or concerns arose.<br><br>R1's medication administration record (MAR) dated August and September 2026, indicated R1 received the following:<br>-ketotifen 0.025% eye drops, one drop into both eyes twice daily at 6:30 a.m. and 8:00 p.m., and one drop in both eyes twice daily as needed for allergic conjunctivitis;<br>-Refresh Plus 0.5% eye drops, one drop into both eyes four (4) times daily at 6:30 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., for dry eyes; and<br>- vitamin D3 50 mcg (micrograms), one tablet by mouth daily at 6:30 a.m., to supplement.<br><br>On September 22, 2026, at 8:36 a.m., during medication cabinet review with unlicensed personnel (ULP)-B, the surveyor observed a shelf dedicated for R1's medications and observed two boxes of eye drops-Refresh eye drops with an open date of September 21, 2026, and Ketotifen eye drops with an open date of September 12, 2026. The surveyor also observed pre-filled pharmacy bubble packs. | 01760 | | |

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| 01760 | Continued From page 45<br><br>R1's provider orders dated May 14, 2026, indicated "see AVS [after visit summary] for instructions," and included orders for vitamin D3 50 mcg once daily and Refresh Plus 0.5% eye drops, one drop in both eyes four times per day. The orders lacked ketotifen eye drops.<br><br>TRANSCRIPTION ERROR<br>On September 23, 2026, at 10:55 a.m., administrator/registered nurse (A/RN)-D stated R1's ketotifen eye drops should not have been scheduled, but available as needed. A/RN-D stated she took responsibility for not discontinuing the eye drops when it changed from scheduled twice daily to as needed on May 14, 2025 (it was instructed on the AVS which the surveyor was unable to observe earlier in the survey). A/RN-D stated she "owned that mistake."<br><br>INCORRECT DOCUMENTATION<br>R1's MAR dated August and September 2026, included the following medication administration documentation:<br>-on August 1, 2, 4, 6, 8, 9, 13, 15, 16, 18, 20, 22, 23, 25, and 27, ULP-F documented their initials with a red circle and reason for holding vitamin D3 50 mcg was "3 days a week;"<br>-on September 1, 5, 12, 16, 17, 19, and 20, ULP-F documented their initials with a red circle and reason for holding vitamin D3 50 mcg was "3 days a week;"<br>-for August, 17 out of 31 days staff documented on the Refresh Plus eye drops 4 times daily as "given" and/or "not available" on the same day indicating inconsistency on whether the medication was available or not; and<br>-for September, 12 out of 21 days staff documented on the Refresh Plus eye drops 4 times daily as "given" and/or "not available" on | 01760 | | |

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| 01760 | Continued From page 46<br><br>the same day indicating inconsistency on whether the medication was available or not.<br><br>On September 22, 2026, at 8:50 a.m., A/RN-D provided R1's MAR (August and September) and while looking at the multiple red circles on the MAR, A/RN-D stated the Refresh eye drops were usually not available due to insurance coverage. She also said resident/family did not want to pay for it out of pocket. The surveyor asked if this had been communicated to R1's medical provider, A/RN-D stated the provider informed her that Ketotifen eye drops (it was later discovered it was not supposed to be scheduled) were more important than the Refresh eye drops but she would reach out to the provider about having the Refresh eye drops discontinued. A/RN-D could not give an explanation why staff were documenting it as given, then at the next scheduled time it was documented as not available, then the following time it was given. A/RN-D stated she would need to complete an investigation to find answers.<br><br>On September 22, 2026, at 10:30 a.m., regarding R1's Refresh eye drops, ULP-B stated supply was always available and had never refused administration. ULP-B and the surveyor observed the medication cabinet and located a box of Refresh eye drops with open date of September 21, 2026, and inside were 29 out of 30 doses of individual eye drops. ULP-B stated when the medication ran out, she would either call the nurse or pharmacy.<br><br>On September 22, 2026, at 12:18 p.m., the surveyor observed ULP-B administer R1's Refresh eye drops, one drop to each eye without hesitation. | 01760 | | |

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| 01760 | Continued From page 47<br><br>On September 23, 2026, at 10:55 a.m., A/RN-D stated R1's vitamin D3 used to be three (3) times per week about a year ago, but staff were documenting that it was not given even though it was given because it was pre-packaged by pharmacy. When the surveyor asked why staff were not following the MAR, A/RN-D stated she disciplined and re-trained ULP-F. A/RN-D was unable to give an explanation why that was not discovered earlier or why ULP-F was not following the instructions on the MAR.<br><br>The licensee's Prescriber's Orders policy effectively August 1, 2021, indicated the licensee would obtain written orders for all medications with which the assisted living facility assist residents. The RN was responsible for implementing medication orders or for delegating the orders to the appropriate paraprofessional.<br><br>The licensee's Medication Documentation policy effective August 1, 2021, indicated each medication administered by staff would be documented in the resident's clinical record. Documentation would be complete, accurate, and legible. Additionally, when medication administration was delegated to unlicensed personnel, the clinical records and/or personnel files would contain documentation of appropriate competency, education and orientation.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01790 SS=F | 144G.71 Subd. 10 Medication management for residents who will | 01790 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32692 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOODNESS AND MERCY HEALTH SERVICES, | 5101 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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|---|---|---|---|---|
| 01790 | Continued From page 48<br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) written information about the medications to be provided;<br>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the | 01790 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01790 | Continued From page 49<br><br>medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. The deficient practice had the potential to affect all residents and staff.<br><br>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). | 01790 | | |

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| 01790 | Continued From page 50<br>The findings include:<br><br>On September 21, 2026, at 10:15 a.m., during entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services for all of licensee's residents.<br><br>ULP-B's Facility Orientation Training Log dated August 31, 2021, indicated ULP-B was trained how to prepare medications for unplanned times away.<br><br>On September 23, 2026, at 11:45 a.m., the surveyor asked administrator/registered nurse (A/RN)-D if there were written procedures for ULPs on leave of absence (LOA) medication setup, and A/RN-D provided their policy. The surveyor asked whether the written procedures could be found on the licensee's electronic health record (Residex), she said she did not know and would need to ask operations manager/RN (OM/RN)-C.<br><br>On September 23, 2026, at 12:33 p.m., A/RN-D provided the LOA policy again along with the "Medication Setup Record" document where staff would document the medication setup. A/RN-D stated the written procedures could be found within the policy, so the surveyor explained the policy lacked facility specific step by step instructions provided by the nurse for ULPs to follow. A/RN-D stated they understood what was being asked and stated they did not have written procedures available.<br><br>The licensee's Medication Management Plan for Residents Away from Home policy effective August 1, 2021, indicated the RN had developed | 01790 | | |

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|---|---|---|---|---|
| 01790 | Continued From page 51<br><br>written procedures/protocols for the ULPs, including special instructions regarding controlled substances, including:<br>- the type of container(s) to be used for the medications appropriate to the facility's medication system;<br>- how the container(s) should be labeled;<br>- written information about the medications to be provided;<br>- documentation requirements including date medications were provided, who received the medications, who provided the medications to the resident, the number of medications that were provided to the resident, and any other information;<br>- how the RN should be notified that the medications were provided and whether the RN should be notified before the medications are given to the resident or the designated representative; and<br>-medications may be set up for the length of the anticipated absence, not to exceed seven (7) calendar days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by: | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 32692 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

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| 01880 | Continued From page 52<br><br>Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on September 21, 2026, at 10:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services for all residents. The current census was four (4) residents.<br><br>During facility tour on September 21, 2026, at 11:24 a.m., the surveyor observed a one-level home with a basement. Upon entry through the front door, across from the living area was the kitchen. Operations manager/registered nurse (OM/RN)-C stated the large metal cabinet within the kitchen was their medication cabinet for all residents. The top half of the cabinet had two doors to access four shelves (one shelf for each resident). The bottom half of the cabinet had drawers. At the top of the cabinet was a black metal latch lock with a keyhole. At that time, the surveyor was unable to determine if it was locked | 01880 | | |

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| GOODNESS AND MERCY HEALTH SERVICES, | 5101 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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| 01880 | Continued From page 53<br><br>as the latch was down but would need to have the key in while turning the knob to lock it.<br><br>On September 22, 2026, at 10:30 a.m., while the surveyor interviewed unlicensed personnel (ULP)-B near the medication cabinet, the surveyor observed the latch to be up (away from the keyhole knob) indicating it was unlocked. The surveyor then proceeded with record review in the dining room adjacent to the kitchen.<br><br>On September 22, 2026, at 12:05 p.m., ULP-B went to the medication cabinet, turned the knob (without key) and opened the latch and pulled out R3's oral medication. ULP-B left the latch up on the cabinet and walked away to administer R3's medication within his room on the other side of the facility. ULP-B returned to the kitchen to wash their hands, went to the unlocked cabinet, and pulled out R3's eye drops from the cabinet and placed it on a tray. ULP-B left the cabinet unlocked and went back to R3's room to administer the eye drops. ULP-B returned to the cabinet to put the bottle of eye drops back and washed hands. ULP-B went to the computer in the living room to observe R1's medication administration record (MAR) then returned to the unlocked cabinet and pulled out R1's eye drops and put it on the tray. ULP-B then washed hands in kitchen and closed the cabinet door without locking it. ULP-B went to R1's room which was next to R3's room and administered his eye drops. ULP-B returned to the cabinet to put the tray back, left it unlocked (latch was up), and went to the computer to document the medication administration. At 12:25 p.m., the surveyor asked ULP-B if they locked the cabinet, ULP-B stated yes, then went to the cabinet, opened a drawer below the doors, pulled out the key and locked the lower drawers (had a separate keyhole lock) | 01880 | | |

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|---|---|---|---|---|
| 01880 | Continued From page 54<br><br>and the latch above the doors by putting the key into the keyhole and turning the knob to lock it. ULP-B stated the key was kept in the drawer and not on their person because they ended up bringing keys home by accident. ULP-E, who was in the living room identified themselves as a supervisor, joined the conversation and both said they kept the key in the drawer of the medication cabinet.<br><br>On September 23, 2026, at 10:55 a.m., the surveyor and administrator/RN (A/RN)-D went to the medication cabinet to observe the locked latch. ULP-G was working so the surveyor asked if they had the key, and ULP-G stated no. ULP-G stated the key was in the same drawer that ULP-B pulled the key out of the day prior. The surveyor opened the unlocked drawer and observed few sets of keys, tray, and garage door opener. The surveyor asked A/RN-D if the cabinet was considered secured, she stated "who is going to go in there?" A/RN-D also stated they utilized a lanyard and wrist band but the key still went home with staff. A/RN-D asked the surveyor for suggestions on what to do.<br><br>The licensee's Storage/Control of Medications policy effective August 1, 2021, indicated when medications are managed outside of a resident's private living space, all prescription drugs must be securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |

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**

GOODNESS AND MERCY HEALTH SERV
5101 63RD AVE N
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

**License Info**

License: HFID 32692

Risk:
License:
Expires on:
CFPM: Eniola Ogundipe
CFPM #: 124395; Exp: 4/18/2027

**Inspection Info**

Report Number: F1043261280
Inspection Type: Full - Single
Date: 9/22/2026 Time: 4:04:43 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

**New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control**
6-501.11 *Priority Level: Priority 3 CFP#: 55*
*MN Rule 4626.1515* Maintain the physical facilities in good repair.
COMMENT: STRIP OF BASEBOARD MISSING FROM WALL BETWEEN KITCHEN FRIDGE AND SINK, WALL PANEL CUTS OFF APPROXIMATELY 1 INCH ABOVE FLOORING AND EXPOSES INTERIOR MATERIALS. ADVISED STAFF TO REINSTALL BASEBOARD WHERE MISSING TO PREVENT STRUCTURAL DAMAGES DUE TO CLEANING, SPILLS, ETC. COMPLY WITH ABOVE RULE.
*Comply By: 9/22/2026 Originally Issued On: 9/22/2026*

# Food & Beverage General Comment

Inspection was completed with Anna Bohnen as the lead Health Regulation Division Nurse Evaluator.

TEMPERATURE (F)
KITCHEN FRIDGE: MILK 37, LETTUCE 40, CHEESE 39

UTENSIL SURFACE TEMPERATURE (F)
DISH MACHINE: TESTED BY FACILITY EVERY FRIDAY. LAST TEST RUN ON 09/18/2026 MEASURED 160F.

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

This facility has a residential kitchen with residential equipment: wooden cabinetry, tiled flooring, smooth walls, textured ceilings, Kitchen Aid dish machine w/sani rinse option. Conditions of equipment and physical facility will be monitored during future inspections – must be brought up to code if at such time they are found to be a concern or risk of contamination.

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

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

**NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

**I acknowledge receipt of the Metro District Office inspection report number F1043261280 from 9/22/2026**

Eniola Ogundipe, Adegbola Ogundipe, & others
CFPM, PIC

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

DEPARTMENT OF HEALTH

# Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

| | |
|---|---|
| **Project No:** SL32692016-0 | **Date:** 9/22/2026 |
| **Facility Name:** Goodness and Mercy Health Services | |
| **Facility Address:** 5101 63rd Ave N, Brooklyn Center, MN 55429 | |

☒ **TAG IDENTIFICATION: 0790**

**SCOPE/ SEVERITY:** Level 1; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   *Comments: The fire extinguisher on the lower level was not installed on the supplied hanger; it was sitting on the floor.*

☒ **TAG IDENTIFICATION: 0800**

**SCOPE/ SEVERITY:** Level 1; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   *Comments: The main level bathroom vent fan cover was clogged with dust.*