



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 26, 2026

Licensee

Ace Homes Inc

3425 77th Avenue North

Brooklyn Park, MN 55443

RE: Project Number(s) SL35375016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. 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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER ACE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3425 77TH AVENUE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35375016-0 On July 20, 2026, through July 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents; 3 receiving services under the Assisted Living Facility license. An immediate correction order was issued on July 20, 2026, for tag identification 1290. During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (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 by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the current assisted living bill of rights (ALBOR) for two of two residents (R1, R2). 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). The findings include: On July 20, 2026, at 10:20 a.m., during entrance conference, licensed assisted living director/manager (LALD/M)-C stated the licensee had a census of three (3) residents. On July 21, 2026, at 11:03 a.m., via email, the surveyor requested the licensee provide a copy of the bill of rights provided to residents.	0 450			

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0 450	Continued From page 2 On July 21, 2026, at 11:08 a.m., the licensee provided their bill of rights titled "[Licensee name] Minnesota Home Care Bill of Rights" which referenced 144A Statutes, not 144G Statutes which the licensee operated under. R1 R1 was admitted on October 23, 2025, to receive assisted living services. R1's current assisted living contract signed December 1, 2025, indicated R1 received a copy of the ALBOR by indicating an "X." R2 R2 was admitted on January 2, 2020, under the licensee's comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's current assisted living contract signed March 12, 2026, indicated R2 received a copy of the ALBOR by indicating an "X." On July 21, 2026, at 2:36 p.m., while reviewing the home care bill of rights received by email on the surveyor's computer, LALD/M-C stated they provided that document as the ALBOR to all residents. When the surveyor explained the bill of rights was for home care, not assisted living, LALD/M-C had a surprised look their face and began writing notes down on paper. The licensee's Notifications policy dated July 23, 2021, indicated all residents would understand their rights as recipients of home care and the services provided. The licensee would provide the resident or the resident's representative with a written notice of rights upon admission and before the date that services are first provided to that	0 450			

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0 450	Continued From page 3 resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	0 480			

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

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0 480	Continued From page 5 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 22, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place the information about the	0 550			

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0 550	Continued From page 6 facilities' grievance procedure with the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances, the contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD), and information for the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 20, 2026, at 11:23 a.m., during the facility tour with licensed assisted living director/manager (LALD/M)-C, the surveyor observed in the common area of the upper level, the licensee lacked a posting with information for the grievance procedure, OOLTC, OOMHDD, and OHFC. LALD/M-C stated they did not have the required postings posted in the facility. Upon entry of a locked office, the surveyor observed contact information for OOLTC, OOMHDD, and OHFC posted on the bulletin board, so LALD/M-C relocated the posting to the common area. On July 22, 2026, at 12:20 p.m., LALD/M-C stated the grievance posting was put up after the	0 550			

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0 550	Continued From page 7 last survey, but was not sure why it was not posted during this survey. LALD/M-C stated he would need to start keeping track of the required postings. The licensee's Grievance policy dated July 23, 2021, indicated a copy of the grievance procedure was conspicuously posted in the residence with the required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (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 information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	0 650			

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0 650	Continued From page 8 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff records included all required content five of five employees (registered nurse (RN)-D, unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-D RN-D was hired to provide comprehensive home care services on July 22, 2021, and began providing assisted living services on August 1, 2021. RN-D provided medication management oversight for all residents and provided training for the licensee's ULPs. RN-D's employee record lacked performance reviews for year 2022, 2023, 2024, and 2025. During phone interview on July 22, 2026, at 10:19 a.m., the surveyor asked RN-D if they ever received a performance review, RN-D stated, "I do not think so, probably not." ULP-B	0 650			

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0 650	Continued From page 9 ULP-B was hired to provide comprehensive home care services on May 1, 2020, and began providing assisted living services on August 1, 2021. On July 20, 2026, through July 22, 2026, at various times, the surveyor observed ULP-B provide services such as medication administration for R1 and R2, behavior redirection, and supervision. ULP-B's training record lacked documentation of demonstrated competency to the RN on medication setup for unplanned leave of absence. ULP-E ULP-E was hired on July 1, 2024, to provide assisted living services to residents. On July 20, 2026, at 3:10 p.m., the surveyor observed ULP-E administer medications to R2. ULP-E's Orientation Checklist indicated ULP-E's start date was June 27, 2024 (employee list indicated July 1, 2024), and was trained on "Overview of Home Care Statute (144A)" on June 27, 2024. ULP-E's training record lacked documentation of the following required content: -orientation to assisted living regulations: overview of assisted living statutes; review of types of assisted living services the employee will provide and provider's scope of license; and principles of person-centered planning/service delivery; and -demonstrated competency to the RN on medication administration and medication setup for unplanned leave of absence.	0 650			

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0 650	Continued From page 10 On July 21, 2026, at 9:48 a.m., licensed assisted living director/manager (LALD/M)-C stated ULP-E completed the orientation with LALD/clinical nurse supervisor (LALD/CNS)-A one-to-one and there was no additional documentation of completed Educare courses (online training program) for ULP-E. On July 22, 2026, at 10:36 a.m., ULP-E stated they received assisted living orientation training by completing paperwork such as written quizzes, leave of absence training, medications, oxygen, blood glucose checks, dressing, and bathing. ULP-F ULP-F was hired on October 13, 2025, to provide assisted living services to residents and terminated employment on March 15, 2026. ULP-F's Staff Supervision Summary dated November 10, 2025, indicated LALD/CNS-A observed ULP-F complete an oral medication administration. ULP-F's Educare transcript dated November 11, 2025, indicated ULP-F completed training on medication administration but lacked demonstrated competency to the RN on medication administration and medication setup for unplanned leave of absence. ULP-H ULP-H was hired on July 10, 2024, to provide assisted living services to residents. ULP-H's Staff Supervision Summary dated October 2, 2024, indicated LALD/CNS-A observed ULP-H on medication administration and met the expectation of proper medication administration.	0 650			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 11 ULP-H's training record included training on medication administration on September 20 and 21, 2024. ULP-H's employee record lacked an annual performance review and documentation of competency evaluation by the RN on medication administration prior to May 26, 2026, and medication setup for unplanned leave of absence. During observation and interview on July 21, 2026, at 2:53 p.m., ULP-H stated they were trained by LALD/CNS-A on how to set up medications for unplanned leave of absence and showed the surveyor on the electronic health record (Residex) how they would complete that task. During phone interview on July 21, 2026, at 1:52 p.m., LALD/CNS-A stated the core skills training was done on Educare upon hire, but they did not evaluate competencies on skills that did not apply to resident's needs at that time. The skills they did observe staff perform were handwashing, meal preparation, and medication administration for all staff. On July 22, 2026, at 12:20 p.m., LALD/M-C stated they completed the performance review for all staff but did not complete them for RN-D and ULP-H. The licensee's Personnel Records policy dated July 23, 2021, indicated personnel records for an employee would include documentation of orientation, performance reviews, and competency evaluations. The Performance Evaluation policy dated July 23,	0 650			

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0 650	Continued From page 12 2021, indicated all paid employees, individual contractors and regularly scheduled volunteers providing assisted living services will participate in an annual performance evaluation at least annually. Documentation of the annual performance evaluation would be maintained in the personnel file. 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: - facility name, location, and license number; - 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; - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; - 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 - 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 650			

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0 650	Continued From page 13 (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment, a baseline TB screening that included a two-step tuberculin (TST) skin test or other evidence of TB testing such as IGRA (a blood test), and TB history and symptom screen for four of four employees (registered nurse (RN)-D, unlicensed personnel (ULP)-E, ULP-F, ULP-H). This had the potential to affect all residents, staff, and visitors.	0 660			

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0 660	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT The licensee's Facility TB Risk Assessment dated February 4, 2024, indicated the facility was at a low risk for TB transmission. The licensee lacked an updated TB Risk Assessment. On July 20, 2026, at 3:00 p.m., licensed assisted living director/manager (LALD/M)-C stated they were unable to locate an updated TB facility risk assessment and the most current one they had was dated February 4, 2024. LALD/M-C stated he would need to check with LALD/clinical nurse supervisor (LALD/CNS)-A. TB SCREENING RN-D RN-D was hired to provide comprehensive home care services on July 22, 2021, and began providing assisted living services on August 1, 2021. RN-D's employee record included a Baseline TB Screening Tool for Health Care Workers form (incomplete) and negative blood test completed on November 23, 2020 (approximately eight (8) months prior to hire date). ULP-E	0 660			

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0 660	Continued From page 15 On July 20, 2026, at 3:10 p.m., the surveyor observed ULP-E administer oral medication to R2. ULP-E was hired on July 1, 2024, to provide direct care and services to residents. ULP-E's employee record included a Baseline TB Screening Tool for Health Care Workers form dated June 21 or 27, 2024, and a negative blood test completed on August 2, 2023 (approximately 11 months prior to hire date). During interview on July 22, 2026, at 10:36 a.m., ULP-E stated she was told to complete a TB test and believed she completed one in year 2024 and should have been in her employee record. ULP-E stated she could contact the clinic to obtain the most current record and provide it to the licensee. ULP-F Former employee ULP-F was hired on October 13, 2025, to provide direct care and services to residents and had a termination date of March 15, 2026 (most recent hire per the licensee's employee list). ULP-F's employee record included a negative blood test completed on November 19, 2025, but lacked a TB history and symptom screen. ULP-H On July 21, 2026, at 2:50 p.m., ULP-H introduced themselves to the surveyor and stated they were working the evening shift (3:00 p.m. to 11:00 p.m.). ULP-H was hired on July 10, 2024, to provide direct care and services to residents.	0 660			

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0 660	Continued From page 16 ULP-H's employee record included a negative blood test completed on September 11, 2024, but lacked a TB history and symptom screen. During phone interview on July 21, 2026, at 1:52 p.m., LALD/CNS-A stated their understanding was they could collect a TST and would be current as long as it was within a year, or they could collect a negative blood test from any time because blood tests did not need to be repeated. LALD/CNS-A did not remember if they completed an updated TB facility risk assessment and stated they would check the computer. Upon completion of the survey, an updated assessment was never provided. The licensee's Tuberculosis Screening/Prevention policy dated July 23, 2021, indicated the director was responsible for conducting the formal TB Risk Assessment and updating it annually and baseline testing was completed on hire for all direct care providers and anyone who visits residents (including volunteers). The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Either test completed within 90 days of hire was acceptable. Additionally, the Facility Tuberculosis Risk	0 660			

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0 660	Continued From page 17 Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH (derived from above MDH guidelines) updated June 2023 (the form licensee used), indicated this document was updated annually to reflect current TB case rates and numbers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680			

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0 680	Continued From page 18 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency disaster plan prominently within the facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on July 20, 2026, at 11:28 a.m., the surveyor asked licensed assisted living director/manager (LALD/M)-C where the EPP was located. LALD/M-C stated the office was always locked and retrieved the key, opened the office door, and pulled the EPP binder from a shelf within the office. LALD/M-C stated during the last survey (approximately two years ago), the surveyor instructed they needed to have the EPP posted prominently and not locked up. During EPP review on July 20, 2026, at 1:55 p.m., the surveyor noted within the binder, there were two sections, one section included papers placed inside a clear plastic sleeve which included templates, blank hazard vulnerability assessment (HVA), blank signature page for EPP review, and	0 680			

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0 680	Continued From page 19 within those documents contained information for another licensee not affiliated to the current licensee. The other section of stapled papers had a prepared date of June 28, 2024. On July 20, 2026, at 3:03 p.m., LALD/M-C stated he reviewed and updated the EPP every three months, and documentation of the review/revision was located in Residex (electronic health record). The surveyor requested a completed HVA, LALD/M-C stated that was also in Residex. The surveyor requested those documents and asked if everything else was included in the EPP. The surveyor did not get a response. Upon survey completion, the surveyor never received the requested documents after requesting them more than once. The licensee's undated EPP lacked evidence of the following required content: - establish and maintain a comprehensive emergency that is customized to facility (included sprinkler system (do not have), security (do not have), and address of a former facility); - develop and maintain an EPP (lacked a facility-based disasters and emerging infectious diseases); - maintain and update annually (lacked all-hazards approach to geographical location-included hurricanes and earthquakes); - policy and procedure for tracking staff and patients; - policy and procedure for evacuation; - policy and procedure for medical documents; - policy and procedure for volunteers; - arrangement with other facilities; - roles under section 1135 waiver declared by secretary; - names and contact information within communication plan;	0 680			

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0 680	Continued From page 20 - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - annual testing including after-action analysis. On July 22, 2026, at 12:20 p.m., LALD/M-C stated the EPP had two (2) plans and needed to condense them and stated they did not test their EPP and stated he would need to include the above missing content as required. The licensee's Emergency Preparedness policy dated July 23, 2021, indicated the licensee would have in place an emergency preparedness plan to assure the safety and well-being of residents and staff during periods of an emergency or disaster that would disrupt services. The policy referenced CMS (Centers for Medicare and Medicaid Services) State Operations Manual Appendix Z. The policy also indicated the emergency disaster plan would be prominently posted. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 775	Continued From page 21	0 775			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790			

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0 790	Continued From page 22 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 790			

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0 790	Continued From page 23	0 790			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970			

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0 970	Continued From page 25 This MN Requirement is not met as evidenced by: Based on 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. This had the potential to affect all residents. 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). The findings include: R1 was admitted on October 25, 2023. R2 began receiving comprehensive services on January 2, 2020, and began receiving assisted living services on August 1, 2021. R1 and R2's [Licensee name] Assisted Living Contract dated December 1, 2025, and March 12, 2026, respectively, included the following sections, waving the licensee's liability for the health and safety or personal property of the resident: -Security/Valuable/Keys, "d. All resident rooms do have security locks. If you choose not to lock your valuables, you assume liability for them;" -Miscellaneous Provisions, "1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability,, and other insurance coverages and shall provide evidence of same by copies of	0 970			

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0 970	Continued From page 26 binders or policies provided to [licensee name] upon request. The resident acknowledges [licensee name] will not be liable to the resident for any personal injury or property damagesuffered by the resident," and "The resident hereby releases [licensee name] from liability for any personal injury or property damage suffered by the resident ...unless caused by the negligence of [licensee name] or its employees or agents;" and -Indemnification, "[Licensee name] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee name] harmless of any claims or damages unless caused solely by negligence of [licensee name]." On July 21, 2026, at 2:36 p.m., licensed assisted living director/manager (LALD/M)-C stated he was not aware the contract included a waiver of liability and explained he went through the contract with each resident. LALD/M-C also stated R1's contract being reviewed was the current version being provided to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01290 SS=G	144G.60 Subdivision 1 Background studies required (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	01290			

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01290	Continued From page 27 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they received a background study (BGS) clearance from NETStudy 2.0 (web-based system used to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living licensee's health facility identification number (HFID) for one of eight employees (registered nurse (RN)-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's HFID was 35375. RN-D obtained their RN licensure on August 29,	01290	During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remained unchanged.		

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01290	Continued From page 28 1985. RN-D was hired on July 22, 2021, to provide nursing services for residents. The licensee's undated NETStudy 2.0 report provided to the surveyor by licensed assisted living director/manager (LALD/manager)-C on July 20, 2026, did include RN-D but their COVID-19 study expired on December 31, 2022. The licensee's employee roster dated April 30, 2026, indicated RN-D was employed by the licensee. During entrance conference on July 20, 2026, at approximately 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated RN-D worked approximately one day a week to help with medication management. RN-D was on-call as back up RN if LALD/CNS-A wasn't available. A posting on the office bulletin board titled "[RN-D's name] Hrs (hours)" documented that RN-D worked approximately one (1) hour per week, most recently on July 18, 2026, from 1:00 p.m. to 2:00 p.m. During interview on July 20, 2026, at 12:55 p.m., LALD/M-C stated he was in charge of completing background studies and re-ran the background study for himself and an unlicensed personnel (ULP) but did not know how RN-D was missed, and would get that taken care of right away. The licensee's Recruitment and Hiring policy dated July 23, 2021, indicated a criminal background check would be submitted to DHS. The results of the background study would be	01290			

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01290	Continued From page 29 maintained in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;	01370			

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01370	Continued From page 30 (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services for three of three unlicensed personnel ((ULP)-E, ULP-F, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on July 20, 2026, at approximately 10:45 a.m., licensed assisted living director/manager (LALD/M)-C stated they were aware of the required contents of the employee records. ULP-E ULP-E was hired on July 1, 2024, to provide direct care and services to residents.	01370			

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01370	Continued From page 31 On July 20, 2026, at 3:10 p.m., the surveyor observed ULP-E administer oral medication to R2. ULP-E's training record lacked the following training and/or competency evaluations: - documentation requirements for all services provided (training only); - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - training on the prevention of falls; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations (training only); and - awareness of commonly used health technology equipment and assistive devices. On July 22, 2026, at 10:45 a.m., ULP-E stated they recalled receiving training by LALD/clinical nurse supervisor (LALD/CNS)-A on blood glucose monitoring, blood pressure, oxygen, and medication. ULP-E then stated they were not trained in the remaining topics. ULP-F Former employee ULP-F was hired on October 13, 2025, to provide direct care and services to residents and had a termination date of March 15, 2026 (most recent hire per the licensee's employee list). ULP-F's training record lacked the following training and/or competency evaluations: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment;	01370			

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01370	Continued From page 32 - training on the prevention of falls; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. ULP-H ULP-H was hired on July 10, 2024, to provide direct care and services to residents. On July 21, 2026, at 2:50 p.m., ULP-H introduced themselves to the surveyor and stated they were working the evening shift (3:00 p.m. to 11:00 p.m.). ULP-H's training record lacked the following training and competency: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -training on the prevention of falls; -standby assistance techniques and how to perform them; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology equipment and assistive devices. During phone interview on July 21, 2026, at 1:52 p.m., LALD/CNS-A stated the core skills training	01370			

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01370	Continued From page 33 was done on Educare (electronic training program) upon hire, but they did not evaluate competencies on skills that did not apply to resident's needs at that time. The skills they did observe staff perform were handwashing, meal preparation, and medication administration for all staff. On July 22, 2026, at 12:20 p.m., LALD/M-C stated they were originally responsible for assigning courses on Educare. LALD/M-C stated they did not have a process in place to ensure all above required trainings were assigned and completed and took responsibility for the lack of training. The licensee's Staff Competency policy dated July 23, 2021, indicated all residents would receive quality services delivered by staff who were educated and competent in the delivery of assisted living services. Training and competency evaluations for all ULP included all the above content and ULP could not work for licensee until they successfully passed the written and demonstration competency evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status;	01380			

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01380	Continued From page 34 (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for three of three unlicensed personnel ((ULP)-E, ULP-F, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on July 20, 2026, at approximately 10:45 a.m., licensed assisted living director/manager (LALD/M)-C stated they were aware of the required contents of the employee records.	01380			

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01380	Continued From page 35 ULP-E ULP-E was hired on July 1, 2024, to provide direct care and services to residents. On July 20, 2026, at 3:10 p.m., the surveyor observed ULP-E administer oral medication to R2. ULP-E's training record lacked the following training and competency evaluations: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On July 22, 2026, at 10:45 a.m., ULP-E stated they recalled receiving training by LALD/clinical nurse supervisor (LALD/CNS)-A on blood glucose monitoring, blood pressure, oxygen, and medication administration. ULP-E then stated they were not trained in the remaining topics. ULP-F Former employee ULP-F was hired on October 13, 2025, to provide direct care and services to residents and had a termination date of March 15, 2026. ULP-F's training record lacked the following training and competency evaluations: -observing, reporting, and documenting resident status;	01380			

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01380	Continued From page 36 -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required (training only). ULP-H ULP-H was hired on July 10, 2024, to provide direct care and services to residents. On July 21, 2026, at 2:50 p.m., ULP-H introduced themselves to the surveyor and stated they were working the evening shift (3:00 p.m. to 11:00 p.m.). ULP-H's training record lacked the following training and competency evaluations: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. During phone interview on July 21, 2026, at 1:52 p.m., LALD/CNS-A stated the core skills training was done on Educare (electronic training	01380			

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01380	Continued From page 37 program) upon hire, but they did not evaluate competencies on skills that did not apply to resident's needs at that time. The skills they did observe staff perform were handwashing, meal preparation, and medication administration for all staff. On July 22, 2026, at 12:20 p.m., LALD/M-C stated they were originally responsible for assigning courses on Educare. LALD/M-C stated they did not have a process in place to ensure all above required trainings were assigned and completed and took responsibility for the lack of training. The licensee's Staff Competency policy dated July 23, 2021, indicated all residents would receive quality services delivered by staff who were educated and competent in the delivery of assisted living services. Training and competency evaluations for all ULP included all the above content and ULP could not work for licensee until they successfully passed the written and demonstration competency evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470			

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01470	Continued From page 38 (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470			

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01470	Continued From page 39 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for four of four employees (registered nurse (RN)-D, unlicensed personnel (ULP)-E, ULP-F, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-D RN-D was hired to provide comprehensive home care services on July 22, 2021, and began providing assisted living services on August 1, 2021. RN-D's personnel record included training on	01470			

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01470	Continued From page 40 overview of Home Care Statutes (144A) and Home Care bill of rights. RN-D's personnel record lacked evidence of orientation training that included the following: -overview of Assisted Living Statutes (144G); -assisted living bill of rights (ALBOR) and staff responsibilities related to ensuring the exercise and protection of those rights -review of types of assisted living services the employee will provide and provider's scope of license; and -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. During phone interview on July 22, 2026, at 10:19 a.m., the surveyor asked RN-D if they received training on assisted living statutes and ALBOR and RN-D "I cannot say specifically it has been so long ago." ULP-E ULP-E was hired on July 1, 2024. On July 20, 2026, at 3:10 p.m., the surveyor observed ULP-E administer oral medication to R2. ULP-E's personnel record lacked evidence of orientation training that included the following: -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 22, 2026, at 10:45 a.m., ULP-E stated they recalled receiving training by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on blood glucose monitoring, blood pressure, oxygen, and medication	01470			

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01470	Continued From page 41 administration. ULP-E then stated they were not trained in the remaining topics. ULP-F Former employee ULP-F was hired on October 13, 2025, to provide direct care and services to residents and had a termination date of March 15, 2026. ULP-F's personnel record lacked evidence of orientation training that included the following: -overview of Assisted Living Statutes (144G); -review of provider's policies and procedures; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of assisted living services the employee will provide and provider's scope of license; and -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-H ULP-H was hired on July 10, 2024, to provide direct care and services to residents. On July 21, 2026, at 2:50 p.m., ULP-H introduced themselves to the surveyor and stated they were working the evening shift (3:00 p.m. to 11:00 p.m.). ULP-H's personnel record lacked evidence of orientation training that included the following: -overview of Assisted Living Statutes (144G); -review of provider's policies and procedures; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; and -review of types of assisted living services the	01470			

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01470	Continued From page 42 employee will provide and provider's scope of license. During entrance conference on July 20, 2026, at 11:00 a.m., LALD/manager (LALD/M)-C stated new hire process included assigning all required training on Educare (electronic training program), then train on resident's plan of care, then the RN would train on medication administration. On July 22, 2026, at 12:20 p.m., LALD/M-C stated they were originally responsible for assigning courses on Educare, but did not have a process in place to ensure all above required trainings were assigned and completed and took responsibility for the lack of training. The licensee's Staff Orientation and Education policy dated July 23, 2021, indicated all staff who provided assisted living services would complete orientation which included the following topics: -overview of Assisted Living Statutes; -review of provider's policies and procedures; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of assisted living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training	01500			

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01500	Continued From page 43 (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	01500			

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01500	Continued From page 44 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment that included the required annual training content for one of three employees (registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-D was hired to provide comprehensive home care services on July 22, 2021, and began	01500			

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01500	Continued From page 45 providing assisted living services on August 1, 2021. RN-D's personnel record included training on the following required content: -reporting maltreatment of vulnerable adults or minors-1 hour completed on January 28, 2022, and November 12, 2023; and -infection control techniques-1 hour completed on October 29, 2023, and February 10, 2024. RN-D's training record lacked the following required annual training topics for years 2022, 2023, 2024, and 2025: -assisted living bill of rights; -review of provider's policies and procedures; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and -the principles of person-centered planning and service delivery. During interview on July 21, 2026, at 9:48 a.m., licensed assisted living director/manager (LALD/M)-C stated since 2024, there were no additional trainings completed for RN-D and thought the requirement for RN-D did not apply since they were an RN. During interview on July 22, 2026, at 10:19 a.m., RN-D stated they did not think they received any annual training after 2024 and was "worried more about CE (continuing education) for board of nursing." RN-D explained they would complete training if the licensee asked them to but they had not been instructed lately. The licensee's Staff Orientation and Education	01500			

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01500	Continued From page 46 policy dated July 23, 2021, indicated all staff that provide assisted living services would complete at least eight (8) hours of education for every 12 months of employment. The policy also included the missing topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed	01530			

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01530	Continued From page 47 the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide supervisors of direct-care staff at least eight hours of initial training and at least two hours of annual training on dementia topics and two hours of initial training on mental illness and de-escalation topics, within 120 working hours of the employment state date, and failed to provide direct-care staff at least eight hours of initial training and at least two hours of annual training on dementia topics and two hours of initial training on mental illness and de-escalation topics within 160 working hours of the employment start date. This deficient practice applied to five of five employees (registered nurse (RN)-D, unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-H). 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	01530			

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01530	Continued From page 48 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on July 21, 2026, at 12:51 p.m., the surveyor was interviewing ULP-B while in the office. R1 walked in and became very agitated verbalizing hate toward the government, yelling profanities, and pacing around the room while ULP-B was setting up their medications. R1's Master Care Plan last updated on September 12, 2025, indicated R1 had schizoaffective disorder, anxiety disorder, major depression, and bipolar disorder. R1's behaviors included verbal aggression toward staff and residents, self-isolation, and socially inappropriate. RN-D RN-D was hired to provide comprehensive home care services on July 22, 2021, and began providing assisted living services on August 1, 2021. RN-D provided medication management oversight for all residents and provided training for the licensee's ULPs. RN-D's posted schedule dated April 9, 26, through July 18, 2026, indicated RN-D worked one (1) hour per week almost every week. RN-D's training record included one (1) hour of dementia training on August 18, 2021. RN-D's training record lacked the full eight (8) hours of initial dementia training, two hours of annual training for year 2022, 2023, 2024, and	01530			

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01530	Continued From page 49 2025. RN-D's record also lacked two (2) hours of initial mental illness training. During phone interview on July 22, 2026, at 10:19 a.m., RN-D stated they provided medication administration training and checked resident's medication sheets while at the facility. RN-D stated they had not completed annual training including dementia and mental illness training in "quite a while." RN-D stated they focused more on completing the required continuing education required for their nursing licensure. RN-D stated they had not been instructed by licensed assisted living director/manager (LALD/M)-C to complete training on Educare lately. ULP-B ULP-B was hired to provide comprehensive home care services on May 1, 2020, and began providing assisted living services on August 1, 2021. On July 20, 2026, through July 22, 2026, at various times, the surveyor observed ULP-B provide services such as medication administration for R1 and R2, behavior redirection, and supervision. The licensee's staff schedule dated July 13 through 26, 2026 (two-weeks), indicated ULP-B worked eight (8) hour shifts, five (5) days each week. ULP-B's training record included 1.75 hours of annual dementia training and one hour of mental illness training completed on July 21, 2025. ULP-B's training record lacked initial dementia training and annual training for year 2021, 2022, 2023, 2024, and full two (2) hours for 2025.	01530			

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01530	Continued From page 50 ULP-E ULP-E was hired on July 1, 2024, to provide assisted living services to residents. On July 20, 2026, at 3:10 p.m., the surveyor observed ULP-E administer medications to R2. The licensee's staff schedule dated July 13 through 26, 2026 (two-weeks), indicated ULP-E worked eight (8) hour shifts, four (4) days each week. ULP-E's training record included 1.75 out of 2 hours required for annual dementia training and 1 hour of mental illness training completed on August 13, 2025. ULP-E's training record lacked initial 8 hours of dementia training and 2 hours of annual training for year 2021, 2022, 2023, 2024. ULP-E's record also lacked initial 2 hours of mental illness training with required topics. ULP-F ULP-F was hired on October 13, 2025, to provide assisted living services to residents and terminated employment on March 15, 2026. ULP-F's training record included 0.5 out of 8 hours of initial dementia training. On July 22, 2026, at 10:11 a.m., via email, the licensee indicated that ULP-E and ULP-F both worked 32-40 hours per week. ULP-H ULP-H was hired on July 10, 2024, to provide assisted living services to residents.	01530			

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01530	Continued From page 51 On July 21, 2026, at 2:53 p.m., the surveyor observed ULP-H onsite beginning their shift and answered questions the surveyor had about medication management. The licensee's staff schedule dated July 13 through 26, 2026 (two-weeks), indicated ULP-H worked eight (8) hour shifts, four (4) days each week. ULP-H's training record included 0.5 out of 8 hours of initial dementia training completed on September 13, 2024. ULP-H's record lacked remaining 7.5 hours of initial dementia training and 2 hours of annual training for year 2025. ULP-H's record also lacked the full 2 hours of mental illness training initially. On July 22, 2026, at 12:20 p.m., LALD/M-C stated they were not sure how many hours of dementia training was required upon hire, but thought four hours, then two hours annually. LALD/M-C was not aware dementia training was transferrable if within 18 months. For mental illness training, LALD/M-C stated they believed four (4) hours initially was required then one (1) hour annually. LALD/M-C stated they were responsible for assigning Educare (online training program) courses for each employee but stated some employees did not get the training completed. They also stated they did not have a process in place to ensure required training was completed and would need help from their assisted house manager. LALD/M-C stated they took responsibility for the missing training. The licensee's Dementia Education policy dated June 23, 2021, indicated supervisors of direct	01530			

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01530	Continued From page 52 care staff would complete eight hours of initial dementia training within 120 hours of the employment start date. In addition, direct care employees would complete eight hours of initial training within 160 hours of the start date. Both supervisors of direct care staff and direct care staff would complete at least two (2) hours of education on topics related to dementia for each 12 months of employment thereafter. The licensee's policies did not address the mental health training requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 53 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two resident's (R1) service plan was revised to include a description of all services provided, and the frequency of each service, according to the resident's current assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During observation on July 21, 2026, at 12:51 p.m., the surveyor interviewed unlicensed personnel (ULP)-B while in the office. R1 walked in and became very agitated by verbalizing hate toward the government, yelling profanities, and paced around the room while ULP-B was setting up their medications. R1's diagnoses included schizoaffective disorder, bipolar disorder, post-traumatic stress disorder (PTSD), insomnia, and suicidal ideations. R1's Assessment dated September 12, 2025, indicated R1 had a history of attempted suicide or	01640			

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01640	Continued From page 54 history of suicidal ideation, verbal aggression toward staff and residents, self-isolation when needs were not met, and demanded other residents to obey him. R1 was independent with transfers. R1's Service Recap Summary dated July 2026, documented by staff R1 received assistance on managing the following behaviors three times per day-agitation, anxiety, verbal aggression, and received assistance with appointment reminders (daily), meal reminders (three times per day), and medication administration once daily and as needed. R1's Service Plan (current service agreement in use) signed December 1, 2025, indicated with an "X" R1 required stand by assist with transfers, verbal reminders to take medications, and medication administration 4-6 times per day. R1's service plan was not revised to include behavior management three times per day, independent with transfers, and updated medication administration frequency. During phone interview on July 21, 2026, at 1:52 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the current service plan used for R1 was within the contract and the medication frequency (4-6 times per day) was accurate at the time of signing because R1 had more medications that were administered. The Service Plan policy dated July 23, 2021, indicated an individualized service plan was implemented for all residents. The service plan must be revised, if needed, based on resident reassessment. The licensee would provide all services required by the current service plan.	01640			

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01640	Continued From page 55 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (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; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (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 (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. This MN Requirement is not met as evidenced	01650			

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01650	Continued From page 56 by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1, R2) receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on October 25, 2023, and had diagnoses including schizoaffective disorder, bipolar disorder, post-traumatic stress disorder (PTSD), insomnia, and suicidal ideations. R1's Service Plan (addendum to assisted living contract) signed December 1, 2025, indicated R1 received medication reminders, medication administration 4-6 times per day, registered nurse (RN) review/reassessments, stand-by assist (SBA) with transfers, and verbal encouragement to eat. During observation on July 21, 2026, at 12:51 p.m., the surveyor interviewed unlicensed personnel (ULP)-B while in the office. R1 walked in and became very agitated by verbalizing hate toward the government, yelling profanities, and paced around the room while ULP-B was setting up their medications. After ULP-B administered R1's medications, R1 left the office.	01650			

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01650	Continued From page 57 R2 R2 began receiving comprehensive home care services on January 2, 2020, and began receiving assisted living services on August 1, 2021. R2 had diagnoses including disorganized schizophrenia, mild intellectual disabilities, and opioid abuse. R2's Service Plan (addendum to assisted living contract) signed March 12, 2026, indicated R2 received medication reminders, medication administration 4-6 times per day, registered nurse (RN) review/reassessments, SBA with transfers, and verbal encouragement to eat, which were the exact same services as R1. On July 20, 2026, at 3:10 p.m., the surveyor observed ULP-E set up and administer medications to R2. R1 and R2's service plan lacked the following required content: - the fees for services (R2 only) and the frequency of each service (SBA with transfers, verbal encouragement to eat, medication reminders); - the identification of staff or categories of staff who will provide the services; and - 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. On July 21, 2026, at 11:44 a.m., via email, the surveyor asked licensee if they utilized the service plan within the assisted living contract or from Residex (electronic health record). At 2:48	01650			

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01650	Continued From page 58 p.m., the surveyor received an email response which only included an attached assisted living contract with service plan for R1 dated October 25, 2024 (not most current service agreement). During phone interview on July 21, 2026, at 1:52 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the current service plan used for all residents was the service plan within the contract. The licensee's Service Plan policy dated July 23, 2021, indicated the service plan would include the following: - a description of the services to be provided and the description may be in the form of the residents care plan developed with the responsible party; - fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; - the identification of the staff or categories of staff who would provide the services; - the schedule and methods of monitoring reviews or assessments of the resident; - the schedule and method of monitoring staff providing services; and - a contingency plan that included the following: - action to be taken if the scheduled service could not be provided; - information and method for a resident or resident's representative to contact the facility; - names and contact information of people the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition; - the identification of and information as to who has the authority to sign for the resident in an emergency; - circumstances in which emergency medical	01650			

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01650	Continued From page 59 services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures	01690			

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01690	Continued From page 60 must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement their current policies and procedures related to management and control of controlled substances for one of one resident (R1) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 20, 2026, at 10:20 a.m., during the entrance conference via phone, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee managed medications for all residents and medications were stored in the closet of a locked office. LALD/CNS-A stated schedule II-controlled substances (high potential risk for abuse) were required to be stored in a locked safe within the closet of the locked office but they currently did not have any schedule II medications, only benzodiazepines which were schedule IV-controlled substances (potential for misuse).	01690			

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01690	Continued From page 61 During facility tour on July 20, 2026, at 11:28 a.m., the surveyor observed a split-level home. Upon entry was the entry and stairs to either go upstairs or downstairs. Upstairs to the left was the living room and kitchen. To the right of the stairs was a hallway including three doors. The door to the left was the bathroom, door to the end of the hallway was a resident's room, then door to the right was the office where medications were stored. During observation on July 20, 2026, at 11:45 p.m., while at the desk within the office, the surveyor sat next to unlicensed personnel (ULP)-B. ULP-B retrieved a plastic basket from the upper shelf of the closet (standard bi-fold closet doors which do not lock) and brought it to the desk. While setting up medications for R1, ULP-B compared the bubble packs against the medication administration record (MAR). The surveyor observed ULP-B set up the following medications: lisdexamfetamine (Vyvanse) 50 milligram (mg) capsule (a schedule II-controlled substance - simulant used to treat attention deficit hyperactivity disorder), loratadine 10 mg tablet (for seasonal allergies), and ibuprofen 400 mg tablet (for pain). ULP-B placed the bubble packs back into the basket and placed the basket on the shelf. The surveyor noted a safe sitting on the same shelf with a key in the keyhole. ULP-B left the office, leaving the office door open, to administer R1's medication down the hall near the top of the stairs. Upon return, ULP-B documented the medication administration and put the medications back into the plastic basket and placed it back on the shelf of the closet, leaving the closet door open. R1's diagnoses included schizoaffective disorder,	01690			

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01690	Continued From page 62 bipolar disorder, post-traumatic stress disorder, and suicidal ideations. R1's provider orders dated December 22, 2025, ordered lisdexamfetamine 50 mg, one capsule by mouth every morning. R1's nursing assessment dated September 12, 2025, assessed R1 required full medication management and setup. The assessment lacked instructions for how R1's medications should have been stored. During phone interview on July 21, 2026, at 1:52 p.m., LALD/CNS-A stated schedule II-controlled substances were required to be double locked. When the surveyor explained that lisdexamfetamine was a schedule II-controlled substance, LALD/CNS-A stated the staff had the office door locked and that there had never been an issue with the count being off (staff count how many capsules in the bubble pack before and after medication administration). During observation and interview on July 21, 2026, at 12:58 p.m., the surveyor asked to observe the contents of the safe. ULP-B pulled the safe from the shelf and opened the safe without touching the key as it was already unlocked. Inside were approximately five (5) bubble packs of non-controlled substance prescriptions (overstock) for various residents. ULP-B explained they count the lisdexamfetamine before and after medication administration and record it within R1's electronic record. During interview on July 22, 2026, at 10:10 a.m., ULP-B stated they were not trained to have R1's lisdexamfetamine locked in the safe but stated	01690			

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01690	Continued From page 63 staff would lock any controlled substances in the safe if instructed. ULP-B was unaware the medication was a schedule II-controlled substance. The Drug Enforcement Administration's (DEA) Controlled Substances-by Controlled Substance Code Number dated June 25, 2026, indicated lisdexamfetamine was a schedule II-controlled substance which had a high potential for abuse which may lead to severe psychological or physical dependence. The licensee's Storage/Control of Medications policy dated July 23, 2021, indicated when controlled substances were being managed, stored, and secured by the licensee, the registered nurse (RN) would provide for security and accountability for the overall management, control, and disposition of those substances. Schedule II-controlled substances were stored in a separately locked compartment. The RN was responsible for establishing the protocol related to monitoring/securing controlled medications based on the initial assessment and risk of diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01690			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a	01730			

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01730	Continued From page 64 written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730			

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01730	Continued From page 65 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately maintain an individualized medication management plan (IMMP) to include all required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 20, 2026, at 10:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the licensee's residents. R1 was admitted to the licensee on October 25, 2023, and began receiving assisted living services. R1's diagnoses included schizoaffective disorder, bipolar disorder, post-traumatic stress disorder, and suicidal ideations. During observation on July 20, 2026, at 11:45 p.m., while at the desk within the office, the surveyor sat next to unlicensed personnel (ULP)-B. ULP-B retrieved a plastic basket from the upper shelf of the closet and brought it to the desk. While setting up medications for R1, ULP-B compared the bubble packs against the medication administration record (MAR). The	01730			

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01730	Continued From page 66 surveyor observed ULP-B set up the following medications: lisdexamfetamine (Vyvanse) 50 milligram (mg) capsule (schedule II-controlled substance-simulant used to treat attention deficit hyperactivity disorder), loratadine 10 mg tablet (seasonal allergies), and ibuprofen 400 mg tablet (pain). ULP-B placed the bubble packs back into the basket, placed the basket on the shelf, and administered the medications to R1. R1's Service Recap Summary dated July 2026, documented by staff that R1 received assistance on managing the following behaviors three times per day-agitation, anxiety, verbal aggression, and received assistance with appointment reminders (daily), meal reminders (three times per day), and medication administration once daily and as needed. R1's record lacked the following required IMMP content: - type of medication storage system, based on resident's needs including how to store schedule II-controlled substances; and - procedures for staff to notify an RN when problems arose. During phone interview on July 21, 2026, at 1:52 p.m., LALD/CNS-A stated scheduled II-controlled substances should be double locked and was not aware Vyvanse was stored with regular medications. On July 22, 2026, at 9:50 a.m., via email, LALD/CNS-A indicated the type of storage system would be indicated in the medication management or service plan. Procedures for notifying the RN of problems were found in the policies and procedures, nursing policies, staff training materials, or resident-specific care plans.	01730			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER ACE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3425 77TH AVENUE NORTH BROOKLYN PARK, MN 55443		
(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
01730	Continued From page 67 During phone interview on July 23, 2026, at 2:45 p.m., LALD/CNS-A referred to R1's contract for the medication assessment and medication plan. The medication assessment was completed upon admission and would not be updated unless there was a change such as self-administration. The licensee's Assessment of Medications policy dated July 23, 2021, indicated based on the results of the medication assessment, the registered nurse (RN) would document an individualized medication management plan, including the following elements: -description of medication storage based on resident need; and -procedures for notifying the RN or licensed health professional regarding problems arising with medication management services. The IMMP would be evaluated/updated as needed with changes in medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER ACE HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3425 77TH AVENUE NORTH BROOKLYN PARK, MN 55443		
(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
03090	Continued From page 68 by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all three residents, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 20, 2026, at 10:23 a.m., during posting review with licensed assisted living director/manager (LALD/M)-C, the surveyor observed two stickers on the front door with the following statement "PROTECTED arlo SMART SECURITY." On the upper level of the split-level house, the following statement was posted on the wall near the stairs "SECURITY NOTICE THIS PROPERTY IS PROTECTED BY ELECTRONIC SURVEILLANCE." The surveyor did not observe a posted electronic monitoring notice with the required statutory language. The surveyor asked LALD/M-C where the required statutory language was posted, they stated it was posted on their storm door at the main entrance, but when they replaced the storm door, it did not get put back up. LALD/M-C stated it was not posted at that time. The licensee's Electronic Monitoring policy dated	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER ACE HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3425 77TH AVENUE NORTH BROOKLYN PARK, MN 55443			
(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
03090	Continued From page 69 July 23, 2021, indicated the licensee would post a sign at each facility entrance accessible to visitors that stated "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

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Establishment Info

ACE HOMES INC
3425 77ST AVENUE SOUTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35375

Risk:
License:
Expires on:
CFPM: None
CFPM #: ; Exp:

Inspection Info

Report Number: F1004261193
Inspection Type: Full - Single
Date: 7/22/2026 Time: 10:00:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 1
Total Priority 3 Orders: 4
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

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

COMMENT: **(ORIGINALLY ISSUED 6/11/24): NO CURRENT STATE CERTIFIED FOOD PROTECTION MANAGER. TO GET A CFPM, YOU MUST TAKE AN APPROVED FOOD SAFETY COURSE, PASS THE EXAM, AND APPLY WITH THE STATE FOR CERTIFICATION. INFORMATION PROVIDED TO OPERATOR. REISSUED 7/22/26.**

Comply By: 7/11/2024 Originally Issued On: 7/22/2026

! New Order: 2-300 Personal Cleanliness

2-301.12A Priority Level: Priority 1 CFP#: 8

MN Rule 4626.0070A Food employees must clean their hands and exposed portions of their arms for 20 seconds, using soap in a handwashing sink that is properly equipped.

COMMENT: **OBSERVED EMPLOYEE(S) WASHING THEIR HANDS FOR LESS THAN 10 SECONDS. ENSURE ALL EMPLOYEES WASH THEIR HANDS FOR A MINIMUM OF 20 SECONDS. DISCUSSED REQUIRED HANDWASHING PROCEDURES WITH OPERATOR ON SITE.**

Comply By: 7/22/2026 Originally Issued On: 7/22/2026

New Order: 2-300 Personal Cleanliness

2-301.12C Priority Level: Priority 3 CFP#: 8

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

COMMENT: **OBSERVED EMPLOYEE TURNING THE HANDWASHING SINK FAUCET OFF WITH THEIR HANDS AFTER WASHING. ENSURE A PAPER TOWEL IS USED TO TURN THE FAUCET OFF TO PREVENT RECONTAMINATION OF HANDS AFTER WASHING. DISCUSSED REQUIRED HANDWASHING PROCEDURES WITH OPERATOR ON SITE.**

Comply By: 7/22/2026 Originally Issued On: 7/22/2026

! New Order: 3-300A Protection from Contamination: limit hand contact, tasting

3-301.11A Priority Level: Priority 1 CFP#: 9

MN Rule 4626.0225A Discontinue bare hand contact with ready-to-eat foods. Use deli tissue, spatulas, tongs, single-use gloves or other dispensing equipment.

COMMENT: **OBSERVED STAFF ON SITE HANDLING READY-TO-EAT ITEMS WITH THEIR BAREHANDS WHILE PREPARING FOOD FOR RESIDENTS. INSPECTOR INSTRUCTED EMPLOYEE TO WASH THEIR HANDS AND DON GLOVES WHILE HANDLING READY-TO-EAT ITEMS. PREVENTING BAREHAND CONTACT WAS DISCUSSED WITH STAFF AND OPERATOR ON SITE.**

Comply By: 7/22/2026 Originally Issued On: 7/22/2026

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs3-302.11A(1) *Priority Level: Priority 1 CFP#: 15**MN Rule 4626.0235A(1)* Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.**COMMENT: RAW SHELL EGGS FOUND STORED OVER READY-TO-EAT ITEMS IN THE KITCHEN REFRIGERATOR. ENSURE RAW ANIMAL FOODS ARE STORED BELOW AND SEPARATE FROM READY-TO-EAT ITEMS. RAW FOOD STORAGE REQUIREMENTS DISCUSSED ON SITE.***Comply By: 7/22/2026 Originally Issued On: 7/22/2026***New Order: 3-500C Microbial Control: date marking**3-501.17B *Priority Level: Priority 2 CFP#: 23**MN Rule 4626.0400B* Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.**COMMENT: (ORIGINALLY ISSUED 6/11/24): NO DATE MARKING OBSERVED ON OPEN PACKAGES OF TCS FOOD ITEMS. ENSURE ALL TCS FOOD ITEMS ARE CLEARLY LABELED WITH THE DATE THEY ARE OPENED AND ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. REISSUED 7/22/26.***Comply By: 6/11/2026 Originally Issued On: 7/22/2026***New Order: 4-200 Equipment Design and Construction**4-204.112A *Priority Level: Priority 3 CFP#: 36**MN Rule 4626.0620A* Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.**COMMENT: (ORIGINALLY ISSUED 6/11/24): NO THERMOMETER IN THE KITCHEN FRIDGE OR FREEZER. PROVIDE AND PLACE IN THE WARMEST PART OF THE UNIT (NEAR THE DOOR) AND MAINTAIN. REISSUED 7/22/26.***Comply By: 7/11/2024 Originally Issued On: 7/22/2026***New Order: 6-300 Physical Facility Numbers and Capacities**6-301.14A *Priority Level: Priority 3 CFP#: 10**MN Rule 4626.1457* Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.**COMMENT: NO HANDWASHING POSTER/SIGN AT HANDWASHING SINK. ENSURE ALL HANDWASHING SINKS USED BY EMPLOYEES (INCLUDING RESTROOMS) ARE EQUIPPED WITH A HANDWASHING SIGN.***Comply By: 7/22/2026 Originally Issued On: 7/22/2026*

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY ANNA BOHNEN.

DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- PREVENTING BAREHAND CONTACT
- SANITIZER USE
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE

-
- FOOD SERVICE PROCEDURES
 - PEST CONTROL
 - PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE AND WITH THE NURSE EVALUATOR ON SITE AT THE CONCLUSION OF THE INSPECTION.

*FLOORS ARE SEALED WOOD, WALLS ARE SMOOTH PAINTED DRYWALL WITH TILE BACKSPLASH, AND CEILING IS "POPCORN" TEXTURE. COUNTERTOPS ARE SEALED SMOOTH STONE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*KITCHEN HAS RESIDENTIAL GRADE EQUIPMENT. ALL FOOD MUST BE PREPARED AND SERVED SAME-DAY.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 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 F1004261193 from 7/22/2026

Establishment Representative

Molly Dougherty

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us



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

Temperature Observations/Recordings

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Establishment Info	Inspection Info
ACE HOMES INC	Report Number: F1004261193
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 7/22/2026
	Time: 10:00:00 AM

Food Temperature: **Product/Item/Unit:** milk; **Temperature Process:** Cold-Holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** cut lettuce; **Temperature Process:** Cold-Holding

Location: Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
ACE HOMES INC	Report Number: F1004261193
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 7/22/2026
	Time: 10:00:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 171 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL35375016-0	Date: July 21, 2026
Facility Name: Ace Homes INC	
Facility Address: 3425 77th Ave N, Brooklyn Park, Minnesota 55443	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: The evacuation map indicated an exit path from the living space through the garage. The emergency exit path shall not go through the garage in the event of a fire or similar emergency, as this space is a higher hazard space than the assisted living.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: It was observed that a chest freezer in the kitchen was being powered by an extension cord that was routed along the wall. Clinical Nurse Supervisor (CNS)-B had staff remove while surveyor was on site.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread

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: During the survey, a portable fire extinguisher was observed with no documentation indicating that the required annual maintenance had been performed by a certified technician. The extinguisher displayed an installation date of 2023, with no evidence of subsequent annual service. Failure to provide the required annual maintenance may result in an extinguisher that is not properly inspected or maintained, reducing its reliability and effectiveness during a fire emergency.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to maintain their FSEP as readily available. The licensee provided multiple policies for the surveyor to review. CNS-B indicated which policy they train on and use in the event of a fire. The policy should be cleaned up and organized so that only relevant policies and procedures are included to avoid confusion for staff and residents.

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

Comments: The facility failed to maintain an accurate building floor plan and properly identify resident rooms. During the survey, the posted facility map depicted the layout of a different building rather than the surveyed facility. In addition, resident room doors were not labeled with room numbers or other identifiers.

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

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

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including

the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of residents that need assistance or any resident-specific procedures to staff for assisting residents during an evacuation.

5. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log showed that drills were conducted 5/2025, 8/2025, 10/2025, 1/2026 and 4/2026.