



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

June 18, 2026

Licensee
The Bardo
6565 Babcock Trail
Inver Grove Heights, MN 55077

RE: Provisional Conditional License Number 423645
Health Facility Identification Number (HFID) 42470
Project Number(s) SL42470015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 5, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **September 16, 2026**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders 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>

CONDITIONAL LICENSE ISSUED:

MDH will issue The Bardo a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if The Bardo is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

- a. **Consultant:** The Bardo will contract with an RN to provide consultation concerning all resident(s) to whom The Bardo provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from The Bardo. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with The Bardo and MDH must review the RN's credentials and approve the selection. The Bardo is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to The Bardo in an effort to help The Bardo align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. The Bardo will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- b. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies The

Bardo and the RN consultant about a change. Each report will be electronically submitted to: HRDConsultantReports.MDH@state.mn.us. The content of the reports will include information such as:

- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- c. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of The Bardo to correct the violations cited during the survey as well as to determine the overall practice of The Bardo in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.
- d. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.
- e. Corrective Action Plan:** The Bardo will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
- i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if The Bardo is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines The Bardo is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to The Bardo. If MDH determines The Bardo is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 Jess Schoenecker directly at: 651-201-3789 or email at: jess.schoenecker@state.mn.us.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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: SL42470015-0 On May 4, 2026, through May 5, 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 two (2) residents receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. 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.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a licensed assisted living director (LALD) was engaged as a managerial official who was in charge of the day-to-day operations and had developed and implemented policies and procedures to ensure licensure requirements were met. This had the potential to impact 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 potential to affect a large portion or all of the residents). The findings include: The licensee's Provisional Assisted Living	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 250	Continued From page 3 Licensure Information and Application signed April 27, 2025, indicated under section Assisted Living Director, LALD-D was, "the person who administers, manages, supervises, or is in general administrative charge of an assisted living facility." Under the section titled "Official Verification of Owner or Authorized Agent", included the following language: "I certify I have read and understand the following:" [a box was filled in before each of the following]: - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (https://www.revisor.mn.gov/statutes/cite/144G) - Assisting Living Licensure rules in Minnesota Rules, chpt. 4659 (https://www.revisor.mn.gov/rules/4659/) - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence f a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 250	Continued From page 4 writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page eighteen (18) was electronically signed by clinical nurse supervisor/owner (CNS/O)-C on April 27, 2025. The licensee had an assisted living license, effective January 30, 2026. On May 5, 2026, at 11:30 a.m., CNS/O-C stated LALD-D was the licensee's LALD but was not actively engaged in the day-to-day operations. CNS/O-C stated LALD-D was a shared LALD with another assisted living facility which was unaffiliated with the licensee and where the LALD spent most of their time. CNS/O-C stated had the licensee's LALD been more involved in the day-to-day operations, the licensee's policies and procedures would have been implemented in a more effective manner and the licensee would have been more in compliance with the 144G assisted living statutes. As a result of the licensee's LALD not being in general administrative charge, the licensee had 22 citations issued as the result of this survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 480	Continued From page 5	0 480			
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 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;	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 480	Continued From page 6 (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). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 5, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 480	Continued From page 7 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			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect both (2) residents 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	0 580			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 580	Continued From page 8 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 April 4, 2026, at 10:00 a.m., during the entrance conference, clinical nurse supervisor/owner (CNS/O)-C stated the licensee was always attempting to improve the quality of care provided by the licensee, but there was no documented quality management program in place. CNS/O-C stated the licensee did not track data or have meeting minutes to review for a quality management program, but licensee would create one now they were aware of the requirement. The licensee's undated Quality Management Program policy indicated the licensee would develop, maintain, and implement services based on findings from data tracking and quarterly meetings of a quality management program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 630	Continued From page 9 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 April 4 and 5, 2026, over the course of the survey, R2 was observed in common areas interacting with staff. R2 required hands-on assistance from staff to ambulate at all times, staff were required to offer fluid via toothettes (disposable foam swabs), and provide medication administration due to R2's lack of muscle strength and mental acuity. R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa (height of 5'4" and a reported 57 pounds, placing R2's body mass index (BMI) at 9.8 (a healthy BMI would be between 18.5 - 24.9)) and was receiving hospice	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 630	Continued From page 10 (end of life) care by an outside agency. R2's Patient Care Plan dated March 31, 2026, provided by an outside hospice agency, indicated R2 required hands-on assistance for ambulation, activities of daily living, monitoring and reporting intake and output, and implementation of safety interventions for falls and pressure ulcers. R2's record lacked an IAPP developed by the licensee to address areas of vulnerability and actions to be taken by the licensee to minimize the risks. On May 4, 2026, at 1:30 p.m., clinical nurse supervisor/owner (CNS/O)-C stated the licensee did not complete an assessment or create an IAPP for any resident. CNS/O-C stated the licensee used the outside hospice provider's records to provide care to residents. CNS/O-C stated no IAPP was created by the licensee to address the vulnerabilities and identify specific interventions to minimize the risks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 640	Continued From page 11 (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living 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 potential to affect a large portion or all of the residents). The findings include: On May 4, 2026, at 10:50 a.m., clinical nurse supervisor/owner (CNS/O)-C provided a tour of the licensee's facility. During the tour CNS/O-C identified multiple telephones provided to all present in the facility. The telephones lacked identification of how a person would summon emergency services via 911. Additionally, the surveyor did not observe the required MAARC contact information posted publicly.	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 640	Continued From page 12 On May 4, 2026, at 10:40 a.m., CNS/O-C stated no outside numbers were required to dial prior to a person dialing 911, but the licensee would create labels and post the required information on each phone. CNS/O-C stated each resident was provided the MAARC contact information when they moved in, but the contact information for MAARC was not publicly posted in a common area for all to review. The licensee's undated Posting Information for Reporting of Crimes or Maltreatment policy indicated the licensee would post information on emergency services and MAARC in a common area of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
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;	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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 13 (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 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-A and ULP-B were both hired on January 8, 2026. ULP-A and ULP-B's records both included a single document titled Assisted Living Training & Competencies Manual as the completed employee record. ULP-A and ULP-B's records lacked all other required content.	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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 14 On May 4, 2026, at 11:20 a.m., clinical nurse supervisor/owner (CNS/O)-C stated the licensee provided all required training, competencies, position descriptions, health screenings, and background studies for every employee, but did not document them. CNS/O-C provided the licensee's training manual which included all the required content and stated the training manual was reviewed together with all employees with competency tests administered, but the licensee failed to document results of the test and the completion of the training. The licensee's undated Employee Record policy indicated all training, orientation, competencies, and required content of the employee record would be maintained in each employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (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	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 15 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a current facility TB risk assessment. The licensee also failed to ensure history and symptoms screening was completed and documented for two of two employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: TB RISK ASSESSMENT On May 4. 2026, at 10:00 a.m., during the entrance conference, clinical nurse supervisor/owner (CNS/O)-C stated the licensee had not completed a Facility TB Risk Assessment Worksheet as required. The surveyor directed CNS/O-C to the Facility TB Risk Assessment Worksheet free website access and CNS/O-C stated the licensee was not aware of the Facility TB Risk Assessment Worksheet and would need	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 16 to complete one. TB SCREENING AND TESTING ULP-A and ULP-B were both hired on January 8, 2026. ULP-A and ULP-B's records both lacked any TB screening or testing. On May 4, 2026, at 11:20 a.m., CNS/O-C stated the licensee had not completed any TB screening or testing for any staff. CNS/O-C stated it was something the licensee was planning on doing but had not yet completed them for any staff member. The licensee's undated Tuberculosis Prevention & Screening Plan policy indicated the licensee would complete a risk assessment and all employees would have screening and testing completed and maintained in the employee's records. 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;	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 680	Continued From page 17 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the emergency disaster plan prominently. 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 potential to affect a large portion or all of the residents). The findings include: On May 4, 2026, at 10:50 a.m., clinical nurse supervisor/owner (CNS/O)-C provided a tour of the licensee's facility. An emergency plan or	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 680	Continued From page 18 binder was not noted to be prominently posted. On May 4, 2026, at 1:20 p.m., CNS/O-C stated the licensee stored the emergency preparedness binder in an office. CNS/O-C stated it was not posted prominently as the licensee was not aware of the requirements to post the plan for all to access in case of an emergency. CNS/O-C stated the licensee would need to create a new binder with required content to post prominently for all to access. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 730	Continued From page 19 (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a resident record with all required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 730	Continued From page 20 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: R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa and received hospice (end of life) care by an outside agency. R2's undated Service Plan included with R2's [licensee] End-of-Life Guest Agreement dated March 26, 2026, indicated the following services were to be provided: - dressing assistance two times (2x) per day and as needed (PRN); - continence assistance five to seven times (5-7x) per day and PRN; - personal laundry 2x per day and PRN; - housekeeping 2x per day and PRN; - stand by assist w/ ambulation eight to ten times (8-10x) per day and PRN; and - overnight monitor three times (3x) per overnight (NOC) shift and PRN. On May 4, 2026, at 1:30 p.m., clinical nurse supervisor/owner (CNS/O)-C stated the licensee did not document some items as they were just part of living at the facility. CNS/O-C stated the licensee was operating under the outside hospice provider's systems and the hospice company documented many of the services that were to be provided. CNS/O-C stated the licensee was not aware every service on the service plan required to be documented as provided as the focus was to provide what residents wanted in the moments and not on the paperwork. The licensee's undated Resident Record policy indicated each resident record would include	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 730	Continued From page 21 documentation of services provided as identified on the resident service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (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	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 790	Continued From page 22 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 May 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 810	Continued From page 23 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa and received hospice (end of life) care by an outside agency. R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, was identified by clinical nurse supervisor/owner (CNS/O)-C as the licensee's	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 910	Continued From page 25 assisted living contract. The contract lacked the licensee's health facility identification (HFID) number, managing agent of the facility, and authorized agent of the facility. On May 4, 2026, at 1:30 p.m., CNS/O-C stated the licensee was not aware of the requirements for an assisted living contract. CNS/O-C stated the licensee would need to develop a new contract with all the required content. The licensee's undated Assisted Living Contract Requirements policy indicated the required content of the assisted living contract would be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 920	Continued From page 26 resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa and received hospice (end of life) care by an outside agency. R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, was identified by clinical nurse supervisor/owner (CNS/O)-C as the licensee's assisted living contract. The contract lacked the following required content: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 920	Continued From page 27 care, a disclosure that it does not hold an assisted living facility with dementia care license; - a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; - a delineation of the cost and nature of any other services to be provided for an additional fee; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; - a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; - billing and payment procedures and requirements; and - disclosure of the facility's ability to provide specialized diets. On May 4, 2026, at 1:30 p.m., CNS/O-C stated the licensee was not aware of the requirements for an assisted living contract. CNS/O-C stated the licensee would need to develop a new contract with all the required content. The licensee's undated Assisted Living Contract Requirements policy indicated the required content of the assisted living contract would be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 930	Continued From page 28	0 930			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 930	Continued From page 29 The findings include: R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa and received hospice (end of life) care by an outside agency. R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, was identified by clinical nurse supervisor/owner (CNS/O)-C as the licensee's assisted living contract. The contract lacked the following required content: - the right under section 144G.54 to appeal the termination of an assisted living contract; - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; and - contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. On May 4, 2026, at 1:30 p.m., CNS/O-C stated the licensee was not aware of the requirements for an assisted living contract. CNS/O-C stated the licensee would need to develop a new contract with all the required content. The licensee's undated Assisted Living Contract Requirements policy indicated the required content of the assisted living contract would be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 940	Continued From page 30	0 940			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO			STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077		
(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
0 940	Continued From page 31 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa and received hospice (end of life) care by an outside agency. R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, was identified by clinical nurse supervisor/owner (CNS/O)-C as the licensee's assisted living contract. The contract lacked the following required content: - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -- whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; -- whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -- whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 940	Continued From page 32 housing support program at any point in time. If so, the limit must be provided; -- whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -- a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -- a statement that residents may be eligible for assistance with rent through the housing support program; and -- a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; - the contact information to obtain long-term care consulting services under section 256B.0911; and - the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On May 4, 2026, at 1:30 p.m., CNS/O-C stated the licensee was not aware of the requirements for an assisted living contract. CNS/O-C stated the licensee would need to develop a new contract with all the required content. The licensee's undated Assisted Living Contract Requirements policy indicated the required content of the assisted living contract would be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 950	Continued From page 33	0 950			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
0 950	Continued From page 34 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa and received hospice (end of life) care by an outside agency. R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, was identified by clinical nurse supervisor/owner (CNS/O)-C as the licensee's assisted living contract. The contract lacked the required verbatim designated representative language and lacked an area for the resident to identify or decline a designated representative. On May 4, 2026, at 1:30 p.m., CNS/O-C stated the licensee was not aware of the requirements for an assisted living contract. CNS/O-C stated the licensee would need to develop a new contract with all the required content. The licensee's undated Assisted Living Contract Requirements policy indicated the required content of the assisted living contract would be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01440	Continued From page 35	01440			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision by a registered nurse (RN) was completed within thirty (30) calendar days of beginning to provide delegated tasks for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO			STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077		
(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
01440	Continued From page 36 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 May 5, 2026, at 10:00 a.m., ULP-A provided medication administration to R2. ULP-A obtained R2's medications from a locked medication drawer in R2's private room. ULP-A dispensed the medications into a medication cup while comparing to R2's medication administration record (MAR) and provided the cup to R2. ULP-A assisted R2 to place the medications into their mouth and then ULP-A used a toothette (a disposable foam swabs) soaked with water to provide fluid to R2 to dissolve the medications in R2's mouth. Once ULP-A verified R2's medications had dissolved, ULP-A cleaned up and ensured documentation was completed in R2's MAR. ULP-A and ULP-B were both hired on January 8, 2026. ULP-A's Assisted Living Training & Competencies Manual dated February 26, 2026, indicated ULP-A was trained to complete delegated tasks including medication administration, but ULP-A's record lacked any documentation of a 30-day delegated task supervision visit from an RN. ULP-B's undated Assisted Living Training & Competencies Manual indicated ULP-B was trained to complete delegated tasks including medication administration, but ULP-B's record lacked any documentation of a 30-day delegated task supervision visit from an RN.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01440	Continued From page 37 On May 4, 2026, at 11:30 a.m., clinical nurse supervisor/owner (CNS/O)-C stated the licensee did train all staff with the same training form but did not complete a 30-day supervision visit by an RN. CNS/O-C stated the licensee trained all the staff prior to any resident was admitted and didn't have a resident for staff to be supervised on within the 30-day period. The licensee's undated Staff Competency Evaluations policy indicated under the Supervision of Staff section all ULPs would be supervised within 30-day for delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01610	Continued From page 38 resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment completed on or before their move in date for one of one resident (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 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 May 5, 2026, at 10:00 a.m., unlicensed personnel (ULP)-A provided medication administration to R2. ULP-A obtained R2's medications from a locked medication drawer in R2's private room. ULP-A dispensed the medications into a medication cup while comparing to R2's medication administration record (MAR) and provided the cup to R2. ULP-A assisted R2 to place the medications into their mouth and then ULP-A used a toothette (a disposable foam swabs) soaked with water to provide fluid to R2 to dissolve the medications in R2's mouth. Once ULP-A verified R2's medications had dissolved, ULP-A cleaned up and ensured documentation was completed in R2's MAR.	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01610	Continued From page 39 R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa (height of 5'4" and a reported 57 pounds, placing R2's body mass index (BMI) at 9.8 (a healthy BMI would be between 18.5 - 24.9)) and was receiving hospice (end of life) care by an outside agency. R2's undated Service Plan included with R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, indicated R2 required medication administration, bathing with the assistance of two staff, standby assist with ambulation, and behavior intervention/redirection services to be provided by the licensee. R2's record lacked an assessment completed with all required content prior to R2 being admitted or on the day R2 admitted under the care of the licensee. On May 4, 2026, at 1:30 p.m., clinical nurse supervisor/owner (CNS/O)-C stated the licensee did not conduct any assessments on residents. CNS/O-C stated the licensee believed they were working under the outside hospice provider's guidance and assessments would be conducted by the hospice company. The licensee's undated Acceptance of Residents policy indicated the licensee's CNS would conduct an initial assessment prior to a resident moving into the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01620	Continued From page 40	01620			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01620	Continued From page 41 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a 14-day assessment and ongoing reassessments which also included all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 May 5, 2026, at 10:00 a.m., unlicensed personnel (ULP)-A provided medication administration to R2. ULP-A obtained R2's medications from a locked medication drawer in R2's private room. ULP-A dispensed the	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01620	Continued From page 42 medications into a medication cup while comparing to R2's medication administration record (MAR) and provided the cup to R2. ULP-A assisted R2 to place the medications into their mouth and then ULP-A used a toothette (a disposable foam swabs) soaked with water to provide fluid to R2 to dissolve the medications in R2's mouth. Once ULP-A verified R2's medications had dissolved, ULP-A cleaned up and ensured documentation was completed in R2's MAR. R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa (height of 5'4" and a reported 57 pounds, placing R2's body mass index (BMI) at 9.8 (a healthy BMI would be between 18.5 - 24.9)) and was receiving hospice (end of life) care by an outside agency. R2's undated Service Plan included with R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, indicated R2 required medication administration, bathing with the assistance of two staff, standby assist with ambulation, and behavior intervention/redirection services to be provided by the licensee. R2's record lacked a 14-day assessment or any assessment with all required content completed by the licensee. On May 4, 2026, at 1:30 p.m., clinical nurse supervisor/owner (CNS/O)-C stated the licensee did not conduct any assessments on residents. CNS/O-C stated the licensee believed they were working under the outside hospice provider's guidance and assessments would be conducted by the hospice company. CNS/O-C stated the licensee was not aware of the Minnesota Administrative Rule 4659.0150 Uniform	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01620	Continued From page 43 Assessment Tool required content. The licensee's undated Acceptance of Residents policy indicated the licensee's CNS would conduct assessments within the appropriate time frames, but the policy lacked identification of Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool content to be used. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01700	Continued From page 44 manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R2), who received 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 May 5, 2026, at 10:00 a.m., unlicensed personnel (ULP)-A provided medication administration to R2. ULP-A obtained R2's medications from a locked medication drawer in R2's private room. ULP-A dispensed the medications into a medication cup while comparing to R2's medication administration record (MAR) and provided the cup to R2. ULP-A assisted R2 to place the medications into their mouth and then ULP-A used a toothette (a disposable foam swabs) soaked with water to provide fluid to R2 to dissolve the medications in R2's mouth. Once ULP-A verified R2's	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01700	Continued From page 45 medications had dissolved, ULP-A cleaned up and ensured documentation was completed in R2's MAR. R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa (height of 5'4" and a reported 57 pounds, placing R2's body mass index (BMI) at 9.8 (a healthy BMI would be between 18.5 - 24.9)) and was receiving hospice (end of life) care by an outside agency. R2's undated Service Plan included with R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, indicated R2 required medication administration, bathing with the assistance of two staff, standby assist with ambulation, and behavior intervention/redirection services to be provided by the licensee. R2's MAR dated May 3-9, 2026, indicated R2 received the following medications: - morphine (schedule two controlled substance) 15 milligrams (mg) by mouth (PO) every four hours (Q4H) for pain and shortness of breath; - morphine 15 mg PO Q4H as needed (PRN) for breakthrough pain; - lorazepam (schedule four controlled substance) 2 mg PO Q4H for anxiety; - lorazepam 2 mg PO twice daily (BID) PRN for breakthrough anxiety; - Haldol (anti-psychotic) 1 mg PO Q4H for agitation; and - Haldol 1 mg PO every two hours (Q2H) PRN. R2's record lacked a face-to-face medication management assessment which included indication for medications, side effects, contraindications, allergic or adverse reactions, and actions to address those issues if they arose.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01700	Continued From page 46 On May 4, 2026, at 1:30 p.m., clinical nurse supervisor/owner (CNS/O)-C stated the licensee did not conduct any face-to-face medication management assessments on residents. CNS/O-C stated the licensee believed they were working under the outside hospice provider's guidance and medication assessments would be conducted by the hospice company and they would direct the care provided by the licensee. The licensee's undated Medication Management Program policy indicated the licensee would conduct a medication management assessment with the required content prior to the implementation of medication services, but the policy lacked indication if the assessment would be completed face-to-face. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	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 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;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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 47 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan (IMMP) with the required content for one of one resident (R2). This practice resulted in a level two violation (a	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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 48 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 May 5, 2026, at 10:00 a.m., unlicensed personnel (ULP)-A provided medication administration to R2. ULP-A obtained R2's medications from a locked medication drawer in R2's private room. ULP-A dispensed the medications into a medication cup while comparing to R2's medication administration record (MAR) and provided the cup to R2. ULP-A assisted R2 to place the medications into their mouth and then ULP-A used a toothette (a disposable foam swabs) soaked with water to provide fluid to R2 to dissolve the medications in R2's mouth. Once ULP-A verified R2's medications had dissolved, ULP-A cleaned up and ensured documentation was completed in R2's MAR. R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa (height of 5'4" and a reported 57 pounds, placing R2's body mass index (BMI) at 9.8 (a healthy BMI would be between 18.5 - 24.9)) and was receiving hospice (end of life) care by an outside agency. R2's undated Service Plan included with R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, indicated R2 required medication administration, bathing with the assistance of two staff, standby assist with ambulation, and	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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 49 behavior intervention/redirection services to be provided by the licensee. R2's MAR dated May 3-9, 2026, indicated R2 received the following medications: - morphine (schedule two controlled substance) 15 milligrams (mg) by mouth (PO) every four hours (Q4H) for pain and shortness of breath; - morphine 15 mg PO Q4H as needed (PRN) for breakthrough pain; - lorazepam (schedule four controlled substance) 2 mg PO Q4H for anxiety; - lorazepam 2 mg PO twice daily (BID) PRN for breakthrough anxiety; - Haldol (anti-psychotic) 1 mg PO Q4H for agitation; and - Haldol 1 mg PO every two hours (Q2H) PRN. The medications were initialed by the licensee's staff as administered to R2. R2's record lacked an IMMP with the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications; - documentation of specific resident instructions; - identification of persons responsible for monitoring medication supplies; and - any resident-specific requirements relating to documenting medication administration. On May 4, 2026, at 1:30 p.m., clinical nurse supervisor/owner (CNS/O)-C stated the licensee did not develop or implement an IMMP for any residents. CNS/O-C stated the licensee believed they were working under the outside hospice provider's guidance and the IMMP would be developed by the hospice company, and they would direct the care provided by the licensee.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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 50 The licensee's undated Medication Management Program policy indicated the licensee would develop a IMMP with all required content for each resident who received medication management by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure controlled medications were securely stored for one of one resident (R2) who had controlled medications. 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:	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01880	Continued From page 51 On May 5, 2026, at 10:00 a.m., unlicensed personnel (ULP)-A provided medication administration to R2. ULP-A obtained R2's medications from a single locked medication drawer in R2's private room. R2's medications included morphine solutab (a schedule II narcotic controlled pain medication in a dissolvable tablet form), lorazepam solutab (a schedule IV controlled benzodiazepine, a central nervous system depressant), and Haldol solutab (a non-controlled antipsychotic). ULP-A dispensed R2's medications into a medication cup and administered them to R2. ULP-A secured R2's medications in the single locked drawer and documented the medication administration. R2 was admitted on March 27, 2026, with the diagnosis of anorexia nervosa (height of 5'4" and a reported 57 pounds, placing R2's body mass index (BMI) at 9.8 (a healthy BMI would be between 18.5 - 24.9)) and was receiving hospice (end of life) care by an outside agency. R2's undated Service Plan included with R2's Bardo End-of-Life Guest Agreement dated March 26, 2026, indicated R2 required medication administration, bathing with the assistance of two staff, standby assist with ambulation, and behavior intervention/redirection services to be provided by the licensee. R2's Medication Administration Record (MAR) dated May 3-9, 2026, indicated R2 received the following medications: - morphine (schedule two controlled substance) 15 milligrams (mg) by mouth (PO) every four hours (Q4H) for pain and shortness of breath; - morphine 15 mg PO Q4H as needed (PRN) for breakthrough pain; - lorazepam (schedule four controlled substance)	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER THE BARDO		STREET ADDRESS, CITY, STATE, ZIP CODE 6565 BABCOCK TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01880	Continued From page 52 2 mg PO Q4H for anxiety; - lorazepam 2 mg PO twice daily (BID) PRN for breakthrough anxiety; - Haldol (anti-psychotic) 1 mg PO Q4H for agitation; and - Haldol 1 mg PO every two hours (Q2H) PRN. The medications were initialed by the licensee's staff as administered to R2. On May 4, 2026, at 1:30 p.m., clinical nurse supervisor/owner (CNS/O)-C stated all resident medications were secured in the same manner in a single locked drawer in each resident room. CNS/O-C stated the licensee did not double-lock controlled medications and did not complete controlled medication counts to ensure diversion did not occur. CNS/O-C stated the outside hospice company was responsible for monitoring and ensured diversion of controlled medications did not occur. The licensee's undated Medication Management Program policy under the Storage of Medications section indicated all narcotics medications would be double locked, but the policy did not indicate the manner in which the licensee would ensure diversion of narcotic medications would be prevented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

The Bardo
6565 Babcock Tr
Inver Grove Heights, MN 55077
Dakota County
Parcel:

Phone:

License Info

License: HFID 42470

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F7963261068
Inspection Type: Full - Single
Date: 5/5/2026 Time: 12:31:25 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
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: NO CERTIFIED FOOD MANAGER CERTIFICATE ON SITE. FACT SHEET SENT TO ESTABLISHMENT REPRESENTATIVE.

Comply By: 5/5/2026 Originally Issued On: 5/5/2026

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: PROVIDE A THERMOMETER FOR THE LOWER LEVEL REFRIGERATOR.

Comply By: 5/5/2026 Originally Issued On: 5/5/2026

Food & Beverage General Comment

MET WITH ESTABLISHMENT REPRESENTATIVE CHRISTIN AMENT AND MDH SURVEYOR BRANDON MUELLER. DISCUSSED THE FOLLOWING-

- EMPLOYEE ILLNESS POLICY AND LOG
- REPORTABLE DISEASES
- SAME-DAY FOOD SERVICE
- VOMIT/FECAL CLEAN UP POLICY
- COOKING TEMPERATURE REQUIREMENTS

THIS IS A RESIDENTIAL HOME USING SAME-DAY FOOD SERVICE AND USES A DISHWASHER TO CLEAN AND SANITIZE DISHES AND UTENSILS.

THERE IS A SECOND KITCHEN IN THE LOWER LEVEL. IN THIS SPACE THE ESTABLISHMENT PROVIDES FOOD FOR VISITING FAMILIES.

FINISHES ARE WOOD CABINETS AND FLOOR, GRANITE COUNTERTOP AND PAINTED CEILING IN THE MAIN KITCHEN AND TILE FLOORING, GRANITE COUNTERTOPS, WOOD CABINETS AND TEXTURED CEILING IN THE LOWER LEVEL KITCHEN.

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 F7963261068 from 5/5/2026



Christin Ament
PIC

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

The Bardo
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F7963261068
Inspection Type: Full
Date: 5/5/2026
Time: 12:31:25 PM

Food Temperature: Product/Item/Unit: SOUP; **Temperature Process:**

Location: MAIN KITCHEN REFRIGERATOR at 37 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: TURKEY AND CHEESE; **Temperature Process:**

Location: MAIN KITCHEN REFRIGERATOR at 41 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: LOWER LEVEL REFRIGERATOR; **Temperature Process:** Ambient Air

Location: 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

The Bardo
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F7963261068
Inspection Type: Full
Date: 5/5/2026
Time: 12:31:25 PM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:**
Location: MAIN LEVEL DISHWASHER RINSE **Equal To** 163 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL42470015	Date: 5/5/2026
Facility Name: The Bardo	
Facility Address: 6565 Babcock Trail, Inver Grove Heights, MN 55077	

☒ 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:

Several small fire extinguishers were supplied around the facility in addition to the required fire extinguishers that did not have current annual service tags. The extra fire extinguishers provided in upper-level closet and in the lower-level kitchen were manufactured in 2024 but did not have an annual inspection tag. All supplied extinguishers should be serviced by a licensed contractor at least once a year. The extra extinguishers should be removed, replaced with new extinguishers, or serviced by a licensed contractor.

No monthly inspection records were provided to the surveyor during inspection. The licensee indicated that monthly inspections on the fire extinguishers were not being recorded. Fire extinguishers should receive monthly visual inspections by facility staff, and the inspections should be recorded.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The FSEP did not include floor plans of the basement level of the facility which included resident rooms. The FSEP should include floor plans that indicate the location of all resident rooms.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide site-specific staff procedures for evacuation. The FSEP should include evacuation plans that include specific steps for staff to take during an emergency evacuation.

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 licensee failed to provide site-specific resident procedures for evacuation. The FSEP should include evacuation plans that include specific steps for residents to take during an emergency evacuation.

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 licensee failed to provide documentation of unique resident needs for evacuation. The FSEP should include information detailing what assistance residents require to evacuate in an emergency and any specific considerations for evacuation that should be observed.

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 provide records of evacuation drills and indicated that no drills had been conducted yet, but that they would be implemented in the near future. Evacuation drills should occur at least twice per shift per year and at least once every other month.