Electronically Delivered

November 6, 2025

Licensee
NG&NG SERVICES GROUP LLC
8615 Birch Boulevard
Inver Grove Heights, MN 55076

RE: Project Number(s) SL37927016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 1, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted no violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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 licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37927	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NG&NG SERVICES GROUP LLC	8615 BIRCH BOULEVARD INVER GROVE HEIGHTS, MN 55076

(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: SL37927016-0 On September 29, 2025, through October 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 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 September 30, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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 and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 790		

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0 790	Continued From page 4 On September 30, 2025, from 1:30 a.m. to 3:30 p.m., the surveyor toured the facility with owner/administrator (O/A)-B; The following was observed: FIRE EXTINGUISHER: During the tour, the portable fire extinguisher cabinets throughout the facility showed that last service was performed April 2024. Per MN State Fire Code, fire extinguishers are required to be professionally serviced annually. On September 30, 2025, at 2:00 p.m., O/A-B, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) 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	0 810		

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0 810	Continued From page 5 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly 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) 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: September 30, 2025, licensed assisted living director (LALD)-A and owner/administrator	0 810		

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0 810	Continued From page 6 (O/A)-B; provided documents on the fire safety evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", undated, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The resident evacuation status was not included as a part of the FSEP. It also does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On September 30, 2025, at 2:00 p.m., LALD-A and O/A-B stated they understood the areas of their policy that were incomplete and would work	0 810		

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0 810	Continued From page 7 on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A and O/A-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-A and O/A-B stated they were using evacuation drills as training. No other training documentation was provided. On September 30, 2025, at 2:00 p.m., LALD-A and O/A-B stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	0 920		

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0 920	Continued From page 8 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 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 assisted living contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's start of services was June 13, 2023. R1's current Lease Agreement (contract) was signed on July 1, 2025.	0 920		

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0 920	Continued From page 9 R1's Initial Residence Service Plan (addendum to contract) was signed on June 14, 2023; the plan indicated the licensee had a Housing with Services license. R1's record lacked a written contract to include: - 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. On September 30, 2025, at 11:54 a.m., administrator/owner (O/A)-B and licensed assisted living director (LALD)-A stated the contract listed the wrong type of licensure. O/A-B further stated the licensee utilized the same Lease Agreement and Residence Service Plan for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
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,	0 940		

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0 940	Continued From page 10 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 940		

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0 940	Continued From page 11 or has potential to affect a large portion or all of the residents). The findings include: R1's start of services was June 13, 2023. R1's current Lease Agreement (contract) was signed on July 1, 2025. R1's Initial Residence Service Plan (addendum to contract) was signed on June 14, 2023. R1's Lease Agreement and Initial Residence Service Plan 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 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	0 940		

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0 940	Continued From page 12 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 September 30, 2025, at 11:54 a.m., administrator/owner (O/A)-B and licensed assisted living director (LALD)-A stated the contract lacked the above required content. O/A-B further stated the licensee contract would lack the same for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
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.	0 950		

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	37927	A. BUILDING: _____ B. WING _____	10/01/2025

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0 950	Continued From page 13 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 ensure the assisted living contract included the designation of representative statutory language for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 950		

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0 950	Continued From page 14 R1's current Lease Agreement (contract) was signed on July 1, 2025. R1's Initial Residence Service Plan (addendum to contract) was signed on June 14, 2023. R1's contract and record lacked the following required content: - 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." On September 30, 2025, at 11:54 a.m., administrator/owner (O/A)-B and licensed assisted living director (LALD)-A reviewed R1's contract and record and stated it lacked the required verbatim content as listed above and would lack the same content for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to	01530		

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01530	Continued From page 16 mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of two employees (unlicensed personnel lead (ULPL)-D, ULP-F). This had the potential to affect all residents and staff. 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: ULPL-D ULPL-D was hired July 6, 2023, to provide direct care services to the residents of the licensee. On September 30, 2025, at 8:08 a.m., the surveyor observed ULPL-D administering medications to R1. ULP-F ULP-F was hired September 8, 2024, to provide direct care services to the residents of the	01530		

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01530	Continued From page 17 licensee. On September 30, 2025, at 3:01 p.m., clinical nurse supervisor (CNS)-E stated being unaware of the requirement for mental health training and de-escalation techniques. CNS-E further stated ULPL-D and ULP-F did not have the required training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640		

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01640	Continued From page 18 the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included chronic diastolic heart failure and type II diabetes. On September 30, 2025, at 7:49 a.m., the surveyor observed unlicensed personnel (ULP)-G applying compression stockings to R1's lower legs. On September 30, 2025, at 8:08 a.m., the surveyor observed ULP lead (ULPL)-D checking R1's blood glucose (BG). R1's provider order dated September 15, 2025, indicated: Check BG every 4 hours and as needed during acute illness/reduced appetite. R1's provider orders dated August 15, 2024, included: Ace wrap/compression stocking.	01640		

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01640	Continued From page 19 Apply Tubi Grip (compression bandage) to BLE (bilateral lower extremity), hand wash, hang to dry, on days, off at bedtime. R1's medication administration record (MAR) dated September 2025, included the above blood glucose order. R1's Service Recap Summary dated September 2025, included the above ace wrap/compression stocking order. R1's unsigned, Resident Service Plan last reviewed/revised September 15, 2024, did not include the blood glucose testing or the compression stockings. On October 1, 2025, at 9:26 a.m., administrator/owner (O/A)-B and O/A-H reviewed R1's current service plan and stated it did not include blood glucose testing or assistance with compression stockings, nor was it signed by the resident and/or resident representative. The licensee's undated, Contents of Service Plans policy indicated: All assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN (registered nurse) and/or other licensed health professional. 3. Service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. 5. Service plans will include: a. A description of the services provided. No further information was provided.	01640		

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01640	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01650		

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01650	Continued From page 21 licensee failed to ensure the service plan included all the required contents 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included chronic diastolic heart failure and type II diabetes. R1's unsigned, Resident Service Plan last reviewed/revised September 15, 2024, indicated services included assistance with dressing, grooming, bathing, toileting, transfers, ambulation, medication administration, housekeeping and laundry. The service plan only included a description of the services to be provided, the fees for services, the frequency of each service, and the identification of staff or categories of staff who will provide the services. R1's Initial Residence Service Plan dated June 14, 2023, lacked the following: - the schedule and methods of monitoring staff providing services On October 1, 2025, at 9:26 a.m. administrator/owner (O/A)-B and O/A-H stated the Initial Residence Service Plan completed for all residents upon admission, was part of the	01650		

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01650	Continued From page 22 resident contract and included all service plan requirements. Upon review of R1's Initial Residence Service Plan, O/A-B and O/A-H stated it did not include the schedule and methods of monitoring staff providing services; this would be the same for all residents. The licensee's undated Contents of Service Plan policy indicated: 5. Service plans will include: e. Schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760		

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01760	Continued From page 23 review, the licensee failed to ensure medications were administered as ordered 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type II diabetes. R1's unsigned, Resident Service Plan last reviewed/revised September 15, 2024, indicated services included medication administration by unlicensed personnel (ULP). R1's provider orders dated August 15, 2024, included the following order: Novolog injectable Flexpen. Inject 5 units subcutaneous (SQ - under the skin) three times daily 15-30 minutes before meals. Hold Novolog if BG (blood glucose) < (less than) 70. If over 400, contact RN (registered nurse). R1's provider order dated August 28, 2025, indicated: Lantus 14 U (units) SQ once daily. D/C (discontinue) Lantus 12 U once daily. R1's medication administration record (MAR) dated September 2025, included the above insulin orders. R1's Lantus was scheduled for 8:00 a.m., and R1's Novolog AM dose was	01760		

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01760	Continued From page 24 scheduled for 9:00 a.m. On September 30, 2025, at 8:08 a.m., the surveyor observed ULP lead (ULPL)-D setting up and administering R1's morning medications including Lantus insulin. ULPL-D stated R1 is given the Lantus first then at 9:00 a.m. will administer the Novolog insulin as they can't give both at the same time. ULPL-D obtained R1's blood glucose level which was 189, then administered the medications. R1 was provided breakfast in her room, following the medication administration. At 9:20 a.m., the surveyor observed ULP-G setting up and administering R1's Novolog insulin. The Novolog insulin was administered approximately one hour after R1 had eaten breakfast. On October 1, 2025, at 11:13 a.m., clinical nurse supervisor (CNS)-E reviewed R1's Novolog insulin order and stated the insulin had not been administered per provider orders and would be considered a medication error. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970		

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01970	Continued From page 25 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were renewed at least every 12 months for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included chronic diastolic heart failure and type II diabetes. On September 30, 2025, at 7:49 a.m., the surveyor observed unlicensed personnel (ULP)-G applying compression stockings to R1's lower legs. R1's provider orders dated August 15, 2024, included: Ace wrap/compression stocking. Apply Tubi Grip (compression bandage) to BLE (bilateral lower extremity), hand wash, hang to dry, on days, off at bedtime. R1's Service Recap Summary dated September 2025, included the above ace wrap/compression stocking order.	01970		

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01970	Continued From page 26 R1's unsigned, Resident Service Plan last reviewed/revised September 15, 2024, did not include the compression stockings. R1's record did not include a current order within the past 12 months for compression stockings. The licensee's 7.18 Medication & Treatment Orders - Renewal policy dated August 1, 2021, indicated: 1. Medication and treatment/therapy orders will be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications or services are new or changed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Food & Beverage Inspection Report

Establishment Info

NG&NG Services Group LLC
8615 Birch Blvd.
Inver Grove Heights, MN 55075
Dakota County
Parcel:

Phone:

License Info

License: 0041368

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Eucharia Unamba
CFPM #: 105401; Exp: 12/21/2026

Inspection Info

Report Number: F1031251136
Inspection Type: Full - Single
Date: 9/30/2025 Time: 11am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT:
DELI HAM IN REFRIGERATOR MEASURED > 41F.
OTHER ITEMS MEASURED 41F OR BELOW.
STAFF STATED THAT REFRIGERATOR WAS OPEN FOR EXTENDED PERIOD FOR BREAKFAST SERVICE,
HAS STAFF REDUCE REFRIGERATOR TEMP.
MONITOR TEMPERATURES.
Comply By: Complied On Site Originally Issued On: 9/30/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT:
ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.
STAFF ORDERED THIN PROBE THERMOMETER IMMEDIATELY. TO BE DELIVERED 10/1/25.
Comply By: 10/3/2025 Originally Issued On: 9/30/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT:
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.
SANI TEST STRIPS LEFT ON SITE.
STAFF PURCHASED TEST KIT - TO BE DELIVERED 10/1/25.
TEST SANI CONCENTRATION (50-200PPM BLEACH) ON REGULAR BASIS.
Comply By: 10/3/2025 Originally Issued On: 9/30/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT:
HANDWASH REMINDER SIGN MISSING FROM BATHROOM HANDWASH STATION.
COPY OF REMINDER SIGN SENT WITH REPORT.
PRINT AND POST SIGN OR PURCHASE SIMILAR.
Comply By: 10/21/2025 Originally Issued On: 9/30/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.114AB *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.
COMMENT:
LOWER CORNER CABINET FILLED WITH MULTIPLE FOOD, EQUIPMENT, AND STAFF ITEMS.
REMOVE ALL ITEMS, CLEAN, AND ORGANIZE SHELVING.
PLACE ALL FOOD ITEMS TOGETHER IN CENTRAL CABINET OR STORAGE AREA.
KEEP STAFF ITEMS SEPARATED FROM KITCHEN ITEMS.
Comply By: 10/21/2025 Originally Issued On: 9/30/2025

! **New Order: 7-200 Toxic Supplies and Applications**
7-201.11A *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.
COMMENT:
SANI SPRAY MEASURED > 200PPM.
DISCUSSED WITH STAFF REASON FOR NEEDING PROPER CONCENTRATION.
HAS STAFF REMAKE SANI SPRAY TO PROPER CONCENTRATION (50-200PPM CHLORINE).
Comply By: Complied On Site Originally Issued On: 9/30/2025

Food & Beverage General Comment

Nurse Evaluator: Wendy Buckholz

All violations discussed with PIC prior to leaving site.

Discussed:
- Cooling and reheating procedure
- Pasteurized egg use
- Pests
- Illness and illness log
- Left side of 2-comp sink is designated for hand washing
- Staff must have sani spray bottle (50-200ppm Chlorine) made and available in kitchen at all times.
- Staff not to save or reheat any leftovers, as discussed on site.

ILLNESS COMPLAINT PROCEDURE:
If any customer complains of illness take these steps:
1. Gather as much information from the customer as possible, such as: name, phone#, date of illness, food consumed.
2. Give customer the illness hotline phone number: 1-877-366-3455.
3. Contact your health inspector: Give inspector information gathered from customer and any other useful information.

Contact inspector prior to any major equipment or building changes; some changes may require plan review to be completed.

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 F1031251136 from 9/30/2025

Eucharia Unamba
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
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Temperature Observations/Recordings

Establishment Info

NG&NG Services Group LLC
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F1031251136
Inspection Type: Full
Date: 9/30/2025
Time: 11am

Food Temperature: Product/Item/Unit: Deli Ham**; Temperature Process:** Cold-Holding
Location: Refrigerator at 45 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Rice**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

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Sanitizer Observations/Recordings

Establishment Info

NG&NG Services Group LLC
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F1031251136
Inspection Type: Full
Date: 9/30/2025
Time: 11am

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Greater Than** 200 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 180 Degrees F.
Comment:
Violation Issued?: No