



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 30, 2026

Licensee
First Light Residential Care
3537 Lee Avenue North
Crystal, MN 55422

RE: Project Number(s) SL37693016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37693	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER FIRST LIGHT RESIDENTIAL CARE L			STREET ADDRESS, CITY, STATE, ZIP CODE 3537 LEE AVENUE NORTH CRYSTAL, MN 55422		
(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: SL37693016-0 On September 8, 2026, through September 10, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three 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.		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a plan of correction (POC) to include all issued tags following their previous routine survey concluded on July 17, 2024. 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	0 340			

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0 340	Continued From page 2 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: The licensee received their correction orders via electronic delivery on August 16, 2024, following their July 17, 2024, survey. The longest period for correction on the correction orders from the date of receipt was 21 days. MN Statute 144G.30 Subd. 5 (c) (1) indicates by the correction order date; the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon complaint investigation, and as otherwise needed. On September 8, 2026, through September 10, 2026, the Minnesota Department of Health conducted a routine survey and re-issued correction order related to the following: - written emergency preparedness plan. The licensee's POC dated August 20, 2024, lacked corrective actions to identify what the licensee was to do to mitigate the identified issues. On September 10, 2026, at 1:20 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they completed some of the corrections; however, they did not know how that part was missing from the binder. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 340			

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0 340	Continued From page 3 days	0 340			
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	0 480			

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

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0 480	Continued From page 5 (FBEIR) dated September 9, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 an infection control program that complied with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, 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	0 510			

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0 510	Continued From page 6 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 8, 2026, at 11:40 a.m., the surveyor requested to review the licensee's infection prevention and control program. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A provided the surveyor with the licensee's infection control policy. The licensee lacked an infection control program with the following content: - demonstration of leadership support; - education and training; - residents, family, and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. On September 8, 2026, at 12:20 p.m., CNS/LALD-A stated they were unaware of the written infection control program requirement. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those residents with documented or suspected infections with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control.	0 510			

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0 510	Continued From page 7 The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated Core Practices should be implemented in all settings where healthcare is delivered including: - leadership support; - education and training on infection prevention; - resident, family and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680			

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0 680	Continued From page 8 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, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked the following required content: - develop and maintain the EPP; - maintain and annual EPP updates; - EPP resident population; - policies and procedures for development of EPP; - names and contact information; - emergency officials contact information; - primary and alternate means for communication;	0 680			

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0 680	Continued From page 9 - methods for sharing information; - procedure for sharing information on occupancy and or needs; - long term care family notifications; and - emergency prep testing requirements. On September 9, 2026, at 1:20 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee was still working on updating their EPP to be compliant with state requirements. CNS/LALD-A stated the content above was missing from their EPP. The licensee's plan of correction (POC) binder dated August 20, 2024, was missing correction plan for EPP. CNS/LALD-A stated they completed the corrections, however, they did not know how that part was missing. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680			

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0 680	Continued From page 10 (21) days	0 680			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 9, 2026, for the specific violations	0 800			

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0 800	Continued From page 11 related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on October 20,	0 970			

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0 970	Continued From page 12 2022, for assisted living services. R2's Assisted Living Contract was signed and dated October 20, 2022. R3 R3 was admitted to the licensee on June 20, 2024, for assisted living services. R3's Assisted Living Contract was signed and dated July 12, 2026. R2 and R3's Assisted Living Contract included the following language waving the licensee's liability for health, safety, or personal property of a resident: Miscellaneous Provisions The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. On September 9, 2026, at 11:45 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were aware of language waiving facility liability and that they had changed/edited the contract language, however, they were not sure whether it met the statute requirement. CNS/LALD-A also stated the same contract was used for all their residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			

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01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	01470			

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01470	Continued From page 14 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation training prior to providing services, for three of three employees (unlicensed personnel (ULP)-B, ULP-C, registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	01470			

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01470	Continued From page 15 ULP-B ULP-B started employment with the licensee on September 17, 2025, to provide assisted living services. On September 9, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications and check blood glucose for R2 in the kitchen area. ULP-C ULP-C started employment with the licensee on May 25, 2026, to provide assisted living services. RN-D RN-D started employment with the licensee on June 19, 2026, to provide assisted living services. ULP-B, ULP-C, and RN-D's training record lacked the following required orientation topics: - review of provider's policies and procedures; and - a review of the types of assisted living services the staff members will be providing and the facility's category of licensure. On September 10, 2026, at 2:20 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had assigned the employees all required orientation training topics. CNS/LALD-A also stated they thought the missing topics were included in Rtask (training software). The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through the licensee will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the	01470			

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01470	Continued From page 16 residents. The policy also indicated orientation topics will include the missing topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01620 SS=E	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	01620			

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01620	Continued From page 17 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 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 ensure the registered nurse (RN) conducted resident reassessment and monitoring at least every 90 calendar days for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01620			

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01620	Continued From page 18 The findings include: R2 R2 was admitted to the licensee on October 20, 2022, for assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated March 12, 2026, indicated R2 received the following services: monitoring and assessments, activity assistance, bathing reminder, bedmaking, grooming, housekeeping, incontinence care, laundry, manage behaviors, manage symptoms, meal assistance, oxygen delivery, blood glucose monitoring, remove garbage, vital signs, and toileting. On September 9, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications and check blood glucose for R2 in the kitchen area. R2's record included three nursing assessments dated December 4, 2025, March 20, 2026, and June 17, 2026. R2's assessment completed on March 20, 2026, was completed on day 106. R3 R3 was admitted to the licensee on June 20, 2024, for assisted living services. R3's Service Plan (Waiver) - Addendum to Contract dated March 12, 2026, indicated R3 received the following services: monitoring and assessments, medication administration, bathing reminder, bedmaking, housekeeping, laundry, manage symptoms, remove garbage, vital signs, and shopping assistance. On September 9, 2026, at 8:19 a.m., the surveyor observed ULP-B check vital signs and administer	01620			

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01620	Continued From page 19 medications to R3 in the kitchen area. R3's record included three nursing assessments dated October 20, 2025, January 28, 2026, and April 26, 2026. R3's assessment completed on January 28, 2026, was completed on day 100. On September 10, 2026, at 1:40 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had informed their on-site registered nurse ((RN)-D) of the late assessments. CNS/LALD-A also stated they would like to schedule assessments at least 10 days earlier. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=E	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	01640			

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01640	Continued From page 20 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services assessed for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee on October 20, 2022, for assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated March 12, 2026, indicated R2	01640			

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01640	Continued From page 21 received the following services: monitoring and assessments, activity assistance, bathing reminder, bedmaking, grooming, housekeeping, incontinence care, laundry, manage behaviors, manage symptoms, meal assistance, oxygen delivery, blood glucose monitoring, remove garbage, vital signs, and toileting. On September 9, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications and check blood glucose for R2 in the kitchen area. R2's Minnesota Department of Human Services Support Plan dated between September 1, 2025, through August 31, 2026, indicated R2 was authorized to receive the following services: homemaking, money management, assistance making appointments, arranging non-medical transportation, breakfast, lunch, supper, snack, individual staff ratio 1:1, assistance with dressing, assistance with grooming, continence care, assistance with self-administration of medication, verbal medication reminders, insulin injections, delegated clinical monitoring, medication set up, insulin draws, manage orientation issues, manage anxiety, manage repetitive behavior, manage agitation, manage injurious behavior, manage aggression, manage physical aggression, mental health need 1, and mental health need 2. R2's service plan lacked the following authorized services appointments, transportation, snack, socialization 1:1, non-medical transportation, and dressing. R2 was not available for interview. R3 R3 was admitted to the licensee on June 20, 2024, for assisted living services.	01640			

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01640	Continued From page 22 R3's Service Plan (Waiver) - Addendum to Contract dated March 12, 2026, indicated R3 received the following services: monitoring and assessments, medication administration, bathing reminder, bedmaking, housekeeping, laundry, managing symptoms, remove garbage, vital signs, and shopping assistance. On September 9, 2026, at 8:19 a.m., the surveyor observed ULP-B check vital signs and administer medications to R3 in the kitchen area. On September 9, 2026, at 10:40 a.m., the surveyor observed R3 prepare and enter to take shower without assistance. R3's Minnesota Department of Human Services Support Plan dated between May 1, 2026, through April 30, 2027, indicated R3 was authorized to receive the following services: homemaking, shopping, money management, assistance making appointments, arranging non-medical transportation, breakfast, lunch, supper, snack, individual staff ratio 1:1, assistance with bathing, assistance with self-administration of medication, verbal medication reminders, medication set up, manage orientation issues, manage anxiety, and manage agitation. R3's service plan lacked the following authorized services: money management, appointments, non-medical transportation, snack, socialization 1:1, and medication set up. R3 was not available for interview. On September 10, 2026, at 2:00 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they thought they had	01640			

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01640	Continued From page 23 included all services authorized in the resident service plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	01940			

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01940	Continued From page 24 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan (TTMP) to include all required content for one of one resident (R2) who received oxygen therapy, and two of two residents (R2, R4) who received blood glucose monitoring. 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: R2 R2 was admitted to the licensee on October 20, 2022, for assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated March 12, 2026, indicated R2 received the following services: monitoring and assessments, activity assistance, bathing reminder, bedmaking, grooming, housekeeping, incontinence care, laundry, manage behaviors, manage symptoms, meal assistance, oxygen delivery, blood glucose monitoring, remove garbage, vital signs, and toileting. On September 8, 2026, at 10:50 a.m., during the	01940			

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01940	Continued From page 25 facility tour the surveyor observed R2 in their room on 2-liter (L) oxygen via nasal cannula from an oxygen concentrator. On September 9, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B check blood glucose for R2 in the kitchen area. ULP-B stated R2's blood glucose was 200 milligrams per deciliter (mg/dL). R2's Provider Orders dated June 9, 2026, indicated monitor and record oxygen saturation two times daily, if less than 90% notify RN. The orders also indicated check blood glucose and record three times daily, if less than 70 mg/dL or greater than 300 mg/dL) notify RN. R4 R4 was admitted to the licensee on July 26, 2022, for assisted living services. R4's Service Plan (Waiver) - Addendum to Contract dated March 12, 2026, indicated R4 received the following services: monitoring and assessments, activity assistance, ambulation, bathing assistance, bedmaking, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, manage symptoms, meal assistance, medication administration, position/reposition, blood glucose monitoring, vital signs, shopping assistance, transfer assistance, and toileting. On September 9, 2026, at 10:20 a.m., the surveyor observed ULP-B check blood glucose for R4 in the kitchen area. ULP-B stated R4's blood glucose was 77 mg/dL. R4's Provider Orders dated December 3, 2025, indicated check blood glucose and record three	01940			

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NAME OF PROVIDER OR SUPPLIER FIRST LIGHT RESIDENTIAL CARE L		STREET ADDRESS, CITY, STATE, ZIP CODE 3537 LEE AVENUE NORTH CRYSTAL, MN 55422			
(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
01940	Continued From page 26 times daily, if less than 70 mg/dL or greater than 300 mg/dL) notify RN. R2 and R4's record lacked a TTMP to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On September 10, 2026, at 1:50 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were not sure why a TTMP was not populating from the nursing assessment. R2 and R4's 90-day assessments were missing a TTMP. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated that RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. type of service to be provided; b. procedures for documenting treatments or therapies; c. procedures for monitoring treatments or therapies to prevent possible complications or	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37693	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER FIRST LIGHT RESIDENTIAL CARE L			STREET ADDRESS, CITY, STATE, ZIP CODE 3537 LEE AVENUE NORTH CRYSTAL, MN 55422		
(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
01940	Continued From page 27 adverse reactions; d. identification of treatment or therapy tasks delegated to unlicensed personnel; and e. procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			



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

Food & Beverage Inspection Report

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Establishment Info

FIRST LIGHT RESIDENTIAL CARE
3537 LEE AVENUE NORTH
Crystal, MN 55422
Hennepin County
Parcel:

Phone:
info@firstlightrc.com

License Info

License: HFID 37693

Risk:
License:
Expires on:
CFPM: SHAMSO MOHAMED
HASSAN
CFPM #: 37288; Exp: 8/20/2027

Inspection Info

Report Number: F1029261308
Inspection Type: Full - Single
Date: 9/9/2026 Time: 11:15:13 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 4
Delivery:

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-307.11 Priority Level: Priority 3 CFP#: 39

MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.

COMMENT: FREE SCREWS ON TOP OF DOWNSTAIRS FREEZER. MOVED DURING INSPECTION.

Comply By: 9/9/2026 Originally Issued On: 9/9/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 Priority Level: Priority 3 CFP#: 55

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: LAMINATE PEELING OFF EXTERIOR CABINET DOORS. EXPOSED WOOD/COMPOSITE WOOD IN AREAS OF DRAWERS AND CABINETRY.

PIC INSTRUCTED TO ENSURE PEELING/FLECKING COVERINGS ARE REPAIRED OR REPLACED. PIC INSTRUCTED TO ENSURE HORIZONTAL CABINET AND DRAWER SURFACES IN CONTACT WITH UTENSILS AND EQUIPMENT ARE NOT EXPOSED WOOD AND ARE COVERED WITH SMOOTH, DURABLE, NON-ABSORBENT, AND EASILY CLEANABLE MATERIAL - SUCH AS THICK HIGH PRESSURE LAMINATE (HPL). LESS ROBUST, BUT STILL NON-ABSORBENT EASILY CLEANABLE APPLICATIONS, ARE OPTIONS FOR THE OTHER DRAWER AND CABINET SURFACES.

Comply By: 11/5/2026 Originally Issued On: 9/9/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A Priority Level: Priority 3 CFP#: 55

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

COMMENT: FOOD DEBRIS AND RESIDUES IN CABINETS AND DRAWERS. PIC INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.

Comply By: 9/11/2026 Originally Issued On: 9/9/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.19 Priority Level: Priority 3 CFP#: 53

MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.

COMMENT: TOILET ROOM DOOR PROPPED OPEN. CORRECTED DURING INSPECTION. PIC INSTRUCTED TO KEEP DOOR CLOSED WHEN NOT MAINTAINING OR CLEANING TOILET ROOM.

Comply By: 9/9/2026 Originally Issued On: 9/9/2026

Food & Beverage General Comment

HRD Surveyor: Benard Nyangena, MBA, BSN, RN Nurse Evaluator II | Health regulation Division

Establishment's kitchen/food service residential in nature with tile floor, wood/composite wood drawers and cabinetry intermittently covered in laminate, composite laminate countertops, and smooth painted walls and ceiling

Establishment uses Whirlpool dishwasher with Sani Rinse to sanitize dishes and glassware in accordance with NSF International NSF/ANSI Standard 184 for Residential Dishwashers which raises the main wash temperature to 135°F (57°C) and the final rinse temperature to 156°F (69°C) with an added time of 0:05 to 1:06

Foodborne illness prevention and food safety reviewed with establishment's PIC

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 F1029261308 from 9/9/2026

SHAMSO HASSAN
PERSON IN CHARGE (PIC)

Trevor McCliment
Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@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

FIRST LIGHT RESIDENTIAL CARE
Crystal
County/Group: Hennepin County

Inspection Info

Report Number: F1029261308
Inspection Type: Full
Date: 9/9/2026
Time: 11:15:13 AM

New Record: Product/Item/Unit: AMBIENT; Temperature Process: Cold-Holding

Location: FRIDGE at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
FIRST LIGHT RESIDENTIAL CARE	Report Number: F1029261308
Crystal	Inspection Type: Full
County/Group: Hennepin County	Date: 9/9/2026
	Time: 11:15:13 AM

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

Location: Greater Than 160 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37693016-0	Date: September 9, 2026
Facility Name: FIRST LIGHT RESIDENTIAL CARE	
Facility Address: 3537 Lee Ave N, Minneapolis, Minnesota 55422	

☒ TAG IDENTIFICATION: 0800	
SCOPE/ SEVERITY: Level 2; Isolated	TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments: A large pile of yard debris and construction material was found in the rear of the property.

1.