Electronically Delivered

April 9, 2026

Licensee
Living Hope Homes- Oak Grove
1805 60th Street East
Inver Grove Heights, MN 55077

RE: Project Number(s) SL39718016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 19, 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. 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
	39718	A. BUILDING: _____ B. WING _____	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES OAK GROVE	1805 60TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39718016 On March 17, 2026, through March 19, 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 five residents; five 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing plan was reviewed twice per year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470		

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0 470	Continued From page 2 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 held as assisted living license. The facility was licensed for a capacity of six residents. On March 17, 2026, at 12:44 p.m. during the entrance conference, the surveyor asked for the facility's staffing plan. On March 17, 2026, at 4:15 p.m., licensed assisted living director (LALD)-A provided the licensee's staffing plan and metrics. LALD-A stated the staffing plan had only been reviewed on February 11, 2026, and not twice yearly as required. LALD-A stated to not being aware of that requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
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	0 480		

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0 480	Continued From page 3 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, 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	0 480		

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0 480	Continued From page 4 (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 March 17, 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		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 5 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a hazard/risk vulnerability assessment and failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. 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	0 680		

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0 680	Continued From page 6 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 Emergency Preparedness Plan Manual dated February 27, 2026, indicated "This document is [licensee name] Emergency Preparedness Program and Plan (EPP). This states our understanding of how we will prepare, manage and conduct actions under emergency conditions. It will be reviewed and updated as needed and at least on an annual basis." The emergency plan failed to include: - a hazard risk vulnerability assessment (HVA) identifying various probable risks/hazards by likelihood of occurrence that is facility and community based; and - a communication plan to include contact information for MN Office of Ombudsman for LTC. On March 19, 2026, at 10:46 a.m., licensed assisted living director (LALD)-A stated not to have knowledge of what a HVA assessment was and stated one was not included in licensee's EPP. In addition, the LALD-A stated the ombudsman contact information was not included in the EPP and did not know this was missing. The licensee's Disaster Planning and Emergency Preparedness policy dated February 1, 2025, indicated the licensee will have in place a general emergency preparedness plan, that is in alignment with the facility's requirement to also comply with CMS Appendix Z. No additional information was provided.	0 680		

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0 680	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/18/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications,	01750		

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01750	Continued From page 9 and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2's diagnoses included chronic respiratory failure and hypertension. R2's service plan dated March 2, 2026, indicated R2 received assistance with medication management. R2's physician orders dated January 8, 2026, included fluticasone propionate/salmeterol 500 micrograms (mcg)/50 mcg - inhale one puff by mouth once daily. R2's medication administration record (MAR)	01750		

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01750	Continued From page 10 dated March 2026, included fluticasone propionate/salmeterol 500 mcg/50 mcg - inhale one puff by mouth once daily. On March 18, 2026, at 9:23 a.m., the surveyor observed unlicensed personnel (ULP)-C administer one puff of fluticasone propionate/salmeterol to R2. After administration, ULP-C did not instruct R2 to rinse mouth and spit out water. On March 18, 2026, at 9:24 a.m., clinical nurse supervisor (CNS)-B stated ULP-C should have rinsed out R2's mouth after administration of fluticasone propionate/salmeterol. CNS-B stated instructions to rinse mouth and spit out water after administration was going to be added to the medication instructions the MAR. Fluticasone propionate/salmeterol manufacturer's instruction dated October 4, 2022, indicated to check the dose counter, open the cover, push the lever, breathe out, inhale quickly, hold breath for 10 seconds, and rinse the mouth. The licensee's Inhaler policy dated February 1, 2025, included inhaler medications must be administered according to the prescriber's orders and verified with the manufacturer's requirements per instructions. Provide residents with the opportunity to rinse out their mouths. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 11 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 review, the licensee failed to ensure medication administration was documented accurately in the electronic medication administration record (EMAR) for one of two residents (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 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: R3's diagnoses included paraplegia, diabetes, and hypertension. R3's service plan dated March 4, 2026, indicated	01760		

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01760	Continued From page 12 R3 received assistance with medication management. R3's provider orders dated January 22, 2026, included calmoseptine ointment - apply to buttocks, scrotum, and left leg-butt fold every incontinence care. On March 18, 2026, at 9:46 a.m., the surveyor observed unlicensed personnel (ULP)-C document calmoseptine ointment administration. The surveyor asked ULP-C why she documented the medication, as she did not administer the ointment. ULP-C stated she should not have documented medication administration for someone else. On March 18, 2026, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated staff should never document medications for someone else and said she will follow up with staff to remind them of this. The licensee's Medication Management - Administration & Setup policy dated February 1, 2025, indicated documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39718	A. BUILDING: _____ B. WING _____	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES OAK GROVE	1805 60TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 13 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not expired for the licensee's house medication supply, medications were maintained bearing the original prescription label and included the date opened of a time-sensitive drug for one of one resident (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 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: EXPIRED MEDICATION: On March 18, 2026, at 10:22 a.m., the locked medication cupboard was reviewed with clinical nurse supervisor (CNS)-B. The following expired house medication supply was observed and confirmed with CNS-B: Chest congestion syrup, expired December 9, 2025; Bisacodyl 5 milligrams (mg), expired October 9, 2025; Antacid, expired October 9, 2025; and Bisacodyl suppositories, expired January 2026, and September 2025.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39718	A. BUILDING: _____ B. WING _____	03/19/2026

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01890	Continued From page 14 On March 18, 2026, at 10:38 a.m., CNS-B stated the expired house supply of medications should have been discarded upon expiration. PRESCRIPTION LABEL AND TIME-SENSITIVE DRUG: R3 was admitted on July 10, 2025, with diagnoses that included paraplegia, diabetes, and hypertension. R3's service plan dated March 4, 2026, indicated R3 received assistance with medication management. R3's provider's order dated April 20, 2024, included: -Melatonin 3 mg; take 1 tablet by mouth at bedtime; and -insulin glargine (Toujeo) 300 unit/milliliter (ml); inject 120 units subcutaneous at bedtime On March 18, 2026, at 10:12 a.m., the surveyor and unlicensed personnel (ULP)-C observed the medication cart. The surveyor observed a bottle of Melatonin 3 mg lacking an original prescription label and ULP-C stated it was R3's. In addition, R3's insulin glargine (Toujeo) insulin pen did not include an opened date. ULP-C stated the insulin pen was opened the night prior and the staff forgot to write an open date on it. On March 18, 2026, at 10:21 a.m., CNS-B stated all medications should have name or prescription label on the medication and staff are to date when opened time sensitive medications such as insulin. The manufacturer's instructions for insulin glargine (Toujeo) Pen dated September 29, 2023,	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LIVING HOPE HOMES OAK GROVE	1805 60TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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01890	Continued From page 15 indicated that once opened (in-use), store pens at room temperature (for a maximum of 56 days (8 weeks). The licensee's Medications - Prescription Drugs & Prohibition policy dated February 1, 2025, included when the licensee receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for one of one resident (R2) with oxygen tanks. This practice resulted in a level two violation (a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39718	A. BUILDING: _____ B. WING _____	03/19/2026

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LIVING HOPE HOMES OAK GROVE	1805 60TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 16 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 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: On March 18, 2026, at 8:20 a.m., the surveyor observed one tall oxygen refillable cylinder stored in a corner by R2's television stand. The oxygen cylinder was stored in an upright position; however, was not stored securely in a rack preventing from falling over. On April 30, 2025, at 12:40 p.m., clinical nurse supervisor (CNS)-B stated oxygen cylinders should be securely stored in an oxygen rack. CNS-B stated the oxygen cylinder was malfunctioned and were waiting for the oxygen supply company to pick it up. CNS-B placed a red tag on the oxygen cylinder and placed inside a secured rack. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to ensure medications were administered according to policy and accepted standards of practice for one of one unlicensed personnel (ULP)-C with documenting medication administration. 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: R4 R4 diagnosis included cerebral palsy. R4's service plan dated February 26, 2026, indicated R4 received assistance with medication management. R4's physician orders dated November 6, 2025,	02320		

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02320	Continued From page 18 included: Cranberry concentrate capsule 500 (milligrams) mg by mouth daily; and Calcium/Vitamin D3 600/400 (international units) IU by mouth twice daily R4's medication administration record (MAR) date March 2026, included: Cranberry concentrate capsule 500 mg by mouth daily; and Calcium/Vitamin D3 600/400 IU by mouth twice daily On March 18, 2026, at 8:01 a.m., the surveyor observed ULP-C set up the above medications in a medication cup and charted administered before administering medications to R4. R2 R2's diagnoses included chronic respiratory failure and hypertension. R2's service plan dated March 2, 2026, indicated R2 received assistance with medication management. R2's physician orders dated January 8, 2026, included: allopurinol 100 mg-2 tablets by mouth daily; bumetanide 2 mg -1 ½ tablets by mouth twice daily; divalproex 250 mg (extended release) ER by mouth twice daily; esomepra Mag Capsule 40 mg by mouth twice daily; fluticasone propionate/salmeterol inhalation 500 microgram (mcg)/50 mcg one puff by mouth daily; Eliquis 5 mg by mouth twice daily; Folic acid 400 mcg by mouth daily; gemfibrozil 600 mg by mouth twice daily;	02320		

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02320	Continued From page 19 glucose contrition capsule 500 mg-400 mg- take 2 capsules daily; hydralazine 50 mg by mouth three times daily; olopatadine sol 0.2%-instill 1 drop both eyes twice daily; pregabalin cap 150 mg by mouth three times daily; Mag oxide 400 mg by mouth daily; metoprolol tartrate 100 mg by mouth twice daily; potassium Chloride micro tab 20 milliequivalent (mEq) ER by mouth twice daily; risperidone 0.5 mg by mouth three times daily; Tab a Vite by mouth daily; venlafaxine cap 150 mg ER by mouth daily; venlafaxine cap 75 mg ER by mouth daily; Vitamin B-1 100 mg by mouth daily; and fluticasone spray 50 mcg-inhale 2 sprays into each nostril daily R2's medication administration record (MAR) dated March 2026, included: allopurinol 100 mg-2 tablets by mouth daily; bumetanide 2 mg -1 ½ tablets by mouth twice daily; divalproex 250 mg (extended release) ER by mouth twice daily; esomepra Mag Capsule 40 mg by mouth twice daily; fluticasone propionate/salmeterol inhalation 500 (microgram) mcg/50 mcg one puff by mouth daily; Eliquis 5 mg by mouth twice daily; Folic acid 400 mcg by mouth daily; gemfibrozil 600 mg by mouth twice daily; Glucose Contrition capsule 500 mg-400 mg- take 2 capsules daily; hydralazine 50 mg by mouth three times daily; olopatadine sol 0.2%-instill 1 drop both eyes twice daily; pregabalin cap 150 mg by mouth three times daily;	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 20 Mag oxide 400 mg by mouth daily; metoprolol tartrate 100 mg by mouth twice daily; potassium Chloride micro tab 20 mEq ER by mouth twice daily; risperidone 0.5 mg by mouth three times daily; Tab a Vite by mouth daily; venlafaxine cap 150 mg ER by mouth daily; venlafaxine cap 75 mg ER by mouth daily; Vitamin B-1 100 mg by mouth daily; and fluticasone spray 50 mcg-inhale 2 sprays into each nostril daily On March 18, 2026, at 9:01 a.m., the surveyor observed ULP-C set up the above medications in a medication cup. ULP-C mixed oral medications with yogurt and charted administered on MAR before administering medications to R2. On March 18, 2026, at 9:24 a.m., clinical nurse supervisor (CNS)-B stated staff are trained to sign medication as administered after medications are taken. The licensee's Medication Management - Administration & Setup policy dated February 1, 2025, indicated of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states:	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 21 "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting resident, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not 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 finding include: On March 17, 2026, at 12:00 p.m. upon arriving at the establishment, the surveyor observed outside the front entrance, a sign stating, "Property under 24-hour video and audio recording". The licensee lacked the required posting/language for electronic monitoring devices. On March 19, 2026, at 10:30 a.m., licensed assisted living director (LALD)-A stated initially the licensee had the electronic monitoring with the statutory language, but the owners did not like	03090		

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03090	Continued From page 22 the sign and changed the sign. The licensee's Electronic Monitoring policy dated February 1, 2025, indicated the licensee must post a sign at each community entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

LIVING HOPE HOMES OAK GROVE
1805 60TH STREET EAST

Inver Grove Heights, MN 55077
Dakota County
Parcel:

Phone:

License Info

License: HFID 39718

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

Inspection Info

Report Number: F1004261076
Inspection Type: Full - Single
Date: 3/17/2026 Time: 12:00:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: **CFPM CERTIFICATION IS BEING USED AT 3 LICENSED ESTABLISHMENTS. PER MINNESOTA STATUTES CHAPTER 144G.41: THE FACILITY MAY SHARE A CERTIFIED FOOD PROTECTION MANAGER 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, MANAGER, AND SUPERVISE EACH FACILITY'S FOOD SERVICE OPERATION.**

EMPLOY AN ADDITIONAL CFPM.
Comply By: 4/17/2026 Originally Issued On: 3/17/2026

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: **(ORIGINALLY ISSUED 10/15/23): OBSERVED RAW SHELL EGGS BEING STORED OVER PRODUCE AND READY-TO-EAT ITEMS IN THE KITCHEN REFRIGERATOR. ENSURE RAW ANIMAL FOODS ARE STORED BELOW AND SEPARATE FROM READY-TO-EAT ITEMS. DISCUSSED STORAGE ORDER REQUIREMENTS WITH STAFF ON SITE. REISSUED 3/17/26**
Comply By: 10/15/2023 Originally Issued On: 3/17/2026

Food & Beverage General Comment

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

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-PREVENTING BAREHAND CONTACT
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION

-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES (SAME-DAY SERVICE ONLY)
-PEST CONTROL
-LOGS
-PHYSICAL FACILITIES AND MAINTENANCE

*THE NURSE EVALUATOR WAS NOT PRESENT ON SITE DURING THE INSPECTION AND ARRIVED AFTER THE INSPECTION CONCLUDED. REPORT WAS DISCUSSED WITH THE REGIONAL EXECUTIVE DIRECTOR ON SITE AND WITH THE NURSE EVALUATOR IN FRONT OF THE PROPERTY.

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

*KITCHEN HAS A 3-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

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

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the Metro District Office inspection report number F1004261076 from 3/17/2026

Molly Dougherty

Kelli Dixon
Regional Executive Director

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

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

Temperature Observations/Recordings

Establishment Info

LIVING HOPE HOMES OAK GROVE
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F1004261076
Inspection Type: Full
Date: 3/17/2026
Time: 12:00:00 PM

Equipment Temperature: Product/Item/Unit: ambient temperature**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

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

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

Sanitizer Observations/Recordings

Establishment Info

LIVING HOPE HOMES OAK GROVE
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F1004261076
Inspection Type: Full
Date: 3/17/2026
Time: 12:00:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment: *per establishment's utensil surface temperature irreversible indicator.
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39718016-0	**Date:** 3/18/2026
Facility Name: LIVING HOPE HOMES OAK GROVE	
Facility Address: 1805 60TH STREET E, INVER GROVE HEIGHTS, MN 55077	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The FSEP 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

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

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Surveyor requested all documentation for staff training on the FSEP from the licensed assisted living director (LALD)-A. LALD-A stated they were using fire drills as training along with a web-based training site that did not include their site specific evacuation plan.

4. 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.