Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 25, 2025

Licensee
Divine Mercy Homes LLC
6717 Jefferson Street Northeast
Minneapolis, MN 55432

RE: Project Number(s) SL41243015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 29, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. 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
Per 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 residents/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 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 the Department of Health 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	41243	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE MERCY HOMES LLC	6717 JEFFERSON STREET NE MINNEAPOLIS, MN 55432

(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: SL41243015-0 On October 28, 2025, through October 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two (2) residents; two (2) receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on April 28, 2025, to receive assisted living services. R1's diagnoses included schizoaffective disorder (is a mental health condition that is marked by a mix of schizophrenia symptoms, such as	0 630		

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0 630	Continued From page 2 hallucinations and delusions, and mood disorder symptoms), anxiety, depression and high blood pressure. R1's Service Plan dated April 25, 2025, indicated R1 received the following services medication administration, set up assistance with grooming, bathing, meal preparation, laundry and housekeeping. R1's IAPP dated October 28, 2025, indicated R1 was at risk of being abused by others, and R1 was not at risk to abuse other vulnerable adults. R1's IAPP lacked: - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults for the identified vulnerabilities. On October 29, 2025, at 10:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the IAPP's were missing specific interventions to minimize the risk for abuse and will need to update them to add specific interventions. The licensee's Individual Abuse Prevention Plan policy dated January 26, 2022, indicated the plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: - other vulnerable adults; - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided.	0 630		

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0 630	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. In addition, the licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees, (unlicensed personnel (ULP)-B).	0 660		

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0 660	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RISK ASSESSMENT On October 28, 2025, at 10:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she does not have a facility TB risk assessment completed because she had been utilizing an incorrect form. TB SCREENING ULP-B ULP-B was hired to provide direct care services for the licensee on March 21, 2025. ULP-B's employee record contained a TB QuantiFERON Gold blood test dated March 18, 2024, greater than 90 days prior to ULP-B's hire date. On October 28, 2025, at 12:00 p.m., the surveyor observed ULP-B prepare lunch for the residents of the facility. On October 29, 2025, at 2:00 p.m., LALD/CNS-A stated she did not realize the year on the blood test was from 2024, she thought it was from 2025 the same year and month ULP-B was hired, so she will have ULP-B complete a new TB blood test.	0 660		

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0 660	Continued From page 5 The licensee's undated Infection Control policy indicated the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health (MDH). New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline Screening Tool for HCWs. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 810		

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0 810	Continued From page 6 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the	0 810		

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0 810	Continued From page 7 potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 29, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "9.06 Fire Policy", dated January 26, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at	0 810		

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0 810	Continued From page 8 the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On October 29, 2025, LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A stated that residents received verbal training, and lacked documentation showing any training was offered or training was scheduled for a future date for residents on the FSEP. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/CNS-A provided documentation showing training was completed at time of hire and annually thereafter. LALD/CNS-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01530	Continued From page 9	01530		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia	01530		

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01530	Continued From page 10 and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics effective July 1, 2025, for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B was hired to provide direct care services for the licensee on March 21, 2025. On October 28, 2025, at 12:00 p.m., the surveyor observed ULP-B prepare lunch for the residents of the facility. ULP-B's employee record showed documentation of 0 hours of mental illness-de-escalation techniques and communication training completed. On October 29, 2025, at 2:00 p.m., licensed	01530		

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01530	Continued From page 11 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the new mental illness training requirements and will have all the staff complete the initial two hours of required training. The licensee's Training Records policy dated January 26, 2022, indicated the licensee will maintain a record of staff training and competency required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 12 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 written service plan was revised to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on April 28, 2025, to receive assisted living services. R1's diagnoses included schizoaffective disorder (is a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms), anxiety, depression and high blood pressure. On October 29, 2025, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Service Plan dated April 25, 2025, indicated R1 received the following services medication	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41243	A. BUILDING: _____ B. WING _____	10/29/2025

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DIVINE MERCY HOMES LLC	6717 JEFFERSON STREET NE MINNEAPOLIS, MN 55432

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01640	Continued From page 13 administration, set up assistance with grooming, bathing, standby assistance with toileting, meal preparation, safety checks, laundry and housekeeping. R1's scheduled services did not include set up assistance with grooming, standby assistance with toileting or meal preparation. On October 29, 2025, at 10:30 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the signed service plan and the actual services do not match because she had been using an older paper version of the service plan and not the one in the electronic charting system and did not realize the services did not match up but will redo the service plans for the resident's in the electronic charting system so they match. The licensee's Service Plan policy dated January 26, 2022, indicated the following: - within 14 days after the date that services are first provided to a resident, the licensee will finalize a written service plan; - the Service plan and any revision shall include a signature or other authentication by licensee and by the resident, or resident's representative, documenting agreement on the services to be provided; - service plan shall be revised, if needed, based on resident reassessments and monitoring; - service plans shall include fees for the services indicated in the service plan; - licensee shall provide information to the residents about any changes to the facilities fees for assisted living services, included with a change in fees is information how to contact the Office of Ombudsman for Long Term Care;	01640		

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	41243	A. BUILDING: _____ B. WING _____	10/29/2025

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01640	Continued From page 14 - the licensee will implement and provide all services indicated in the service plan; - service plans and any revisions or updates shall be entered into the resident's record, including notice of change in fees when applicable; and - staff providing services indicated in the service plan shall be informed of the current written service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriber orders for medications were correctly transcribed, for one of two residents (R1).	01760		

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	41243	A. BUILDING: _____ B. WING _____	10/29/2025

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01760	Continued From page 15 This practice resulted in a level two violation (a violation that did not harm a client's/resident's health or safety but had the potential to have harmed a client's/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 clients/residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on April 28, 2025, to receive assisted living services. R1's diagnoses included schizoaffective disorder (is a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms), anxiety, depression and high blood pressure. On October 29, 2025, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Service Plan dated April 25, 2025, indicated R1 received the following services medication administration, set up assistance with grooming, bathing, standby assistance with toileting, meal preparation, safety checks, laundry and housekeeping. R1's Provider Orders signed on August 14, 2025, included acetaminophen ES 500 milligrams (mg), give two (2) tablets by mouth three times a day. R1's Medication Administration Record (MAR)	01760		

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01760	Continued From page 16 dated September 2025 lacked acetaminophen ES 500 mg medication. On October 29, 2025, at 9:05 a.m., licensed assisted living director/clinical nurse supervisor (CNS)-A stated she had wanted to get the order for the acetaminophen changed to as needed instead of three times daily and agrees the medication was not currently on the MAR so will add it back on the MAR until she can get the signed order to change it to as needed. The licensee's Medication and Treatment Orders policy dated January 26, 2022, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. The licensed nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. A residence MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	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 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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	41243	A. BUILDING: _____ B. WING _____	10/29/2025

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01890	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of two residents (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: On October 29, 2025, at 8:00 a.m., the surveyor observed the locked medication cabinet with unlicensed personnel (ULP)-C and observed and verified the following expired medications for R2: - ibuprofen 600 milligrams (mg), expired in March 2023; and - docusate 100 mg, expired June 2025. On October 29, 2025, at 8:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 came to the facility with medications from a different facility and the ibuprofen must have been included in those medications and should have been destroyed. LALD/CNS-A stated she missed the expired docusate when she completed her weekly medication check. The licensee's Medication Disposal policy dated January 26, 2022, indicated expired medications	01890		

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01890	Continued From page 18 managed by licensee will be disposed of according to the accepted practices of the Minnesota board of pharmacy and the labels from the containers will be destroyed. Upon disposition, the facility must document in the residence record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Palf Divine Mercy Homes LLC
6717 Jefferson Street Ne
Fridley, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 41243

Risk:
License:
Expires on:
CFPM: Patricia Amajuoyi
CFPM #: 108723; Exp: 12/5/2027

Inspection Info

Report Number: F1025251194
Inspection Type: Full - Single
Date: 10/28/2025 Time: 11:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Dishwasher thermometer available on site, NSF Residential unit
Discussed health and hygiene, illness exclusion, TMD and cook temperatures of food, sanitizing of food contact surfaces, cold holding and equipment cook-serve exemption, food source, date marking

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 F1025251194 from 10/28/2025

Particia

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@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

Palf Divine Mercy Homes LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1025251194
Inspection Type: Full
Date: 10/28/2025
Time: 11:30 AM

New Record: **Product/Item/Unit:** Ambient**; Temperature Process:** Cold-Holding
Location: Downstairs refrigerator at 30 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk**; Temperature Process:** Cold-Holding
Location: Upstairs refrigerator at 42 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** Freezer**; Temperature Process:**
Location: at Degrees F.
Comment: Garage, frozen
Violation Issued?: No