



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 6, 2026

Licensee
Hope Homes LLC
8035 Stevens Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL38736016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 11, 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:

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- 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,



Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38736	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2026
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NAME OF PROVIDER OR SUPPLIER HOPE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8035 STEVENS AVENUE SOUTH BLOOMINGTON, MN 55420
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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
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL38736016-0</p> <p>On February 9, 2026, through February 11, 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 was one resident; one receiving services under the Assisted Living license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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0 480	<p>Continued From page 1</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are</p>	0 480		
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0 480	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 10, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p>	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	<p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(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.</p> <p>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) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for the licensee's one resident (R1).</p> <p>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).</p>	0 630		

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0 630	<p>Continued From page 4</p> <p>The findings include:</p> <p>R1 was admitted to the facility on July 18, 2025, with diagnoses including hypertension.</p> <p>R1's Care Plan dated October 17, 2025, indicated R1 received services to include medication reminders, prescription management and appointment scheduling by the registered nurse.</p> <p>On February 9, 2026, at 10:00 a.m., the nurse evaluator entered the facility and noticed a strong smell of cigarette smoke throughout the house. Clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated R1 was recently diagnosed with renal failure has experienced increased weakness and fatigue. Due to the fatigue and weakness, R1 has been vaping in the house. He tells staff that he is tired and doesn't have the energy to go outside to the smoking area, so will vape inside. He is repeatedly encouraged to go outside, but states he doesn't have the energy. LALD/CNS-A stated R1 was moved from a bedroom on the second floor to a first floor bedroom, due to weakness, and to make it easier to go outside to smoke. R1 will go outside, at times, but will still vape in his room. Staff continue to monitor and encourage him to smoke in the designated smoking area.</p> <p>R1's record included an Abuse Prevention Plan dated February 9, 2026. The plan lacked documentation of interventions related to safe smoking.</p> <p>On February 10, 2026, at 11:30 a.m., LALD/CNS-A stated she talked to licensee employees about monitoring and encouraging R1 to go out to the designated smoking area to vape</p>	0 630		
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0 630	<p>Continued From page 5</p> <p>and smoke. LALD/CNS-A verified the IAPP lacked documented interventions to encourage R1 to smoke safely.</p> <p>The licensee's Individual Abuse Prevention Plan policy dated August 1, 2023, verified the plan will include "an individualized review or assessment of the person's susceptibility to abuse by another individual, including other 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 or other vulnerable adults."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 630		
0 650 SS=F	<p>144G.42 Subd. 8 (a) Staff records</p> <p>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p>	0 650		

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0 650	<p>Continued From page 6</p> <p>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p> <p>CNS/LALD-A The licensee's Employee List form indicated CNS/LALD-A had a hire date of September 15, 2023. CNS/LALD-A provided direct care nursing services to the licensee's residents.</p> <p>CNS/LALD-A's record lacked evidence of an annual performance review.</p> <p>ULP- B The licensee's Employee List form indicated ULP-B had a hire date of September 15, 2023.</p>	0 650		
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0 650	<p>Continued From page 7</p> <p>The surveyor observed ULP-B providing direct care services to the licensee's residents.</p> <p>ULP-B's record lacked evidence of an annual performance review.</p> <p>On February 10, 2026, at 11:30 a.m., CNS/LALD-A stated annual performance reviews were not completed for herself or ULP-B. CNS/LALD-A stated she completed 30-day assessments for licensee employees, but was not aware of the requirement for completion of annual performance reviews.</p> <p>The licensee's Supervision of Nurse's and Licensed Health Professionals policy dated August 1, 2023, indicated the licensee "will conduct annual performance evaluations for all nurses and other health professionals on staff."</p> <p>No further information was provided</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 650		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(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;</p>	0 680		

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0 680	<p>Continued From page 8</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Appendix Z Emergency Preparedness (EP) Plan contained all the required components. This had the potential to effect the resident, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's EP plan, dated August 25, 2025, lacked the following required content: -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise and a second full-scale</p>	0 680		
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0 680	<p>Continued From page 9</p> <p>exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise.</p> <p>On February 10, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated she was not aware of the requirement to complete a full-scale exercise. CNS/LALD-A stated she completes fire drills, as required, but was not aware of the above requirement.</p> <p>The licensee's Emergency Preparedness policy dated August 1, 2023, verified the licensee "will conduct, at minimum, two emergency preparedness drills every 12 months-these drills to not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise or a tabletop exercise focused on our assisted living setting. Exercises and drills will be designed to test our emergency plan and to identify gaps and areas for improvement."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 775 SS=D	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by:</p>	0 775		

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0 775	<p>Continued From page 10</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 775		
0 780 SS=E	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of</p>	0 780		

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NAME OF PROVIDER OR SUPPLIER HOPE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8035 STEVENS AVENUE SOUTH BLOOMINGTON, MN 55420
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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
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0 780	<p>Continued From page 11</p> <p>bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</p> <p>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.</p> <p>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).</p> <p>The findings include:</p>	0 780		
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0 780	Continued From page 12 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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	0 810		

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0 810	<p>Continued From page 13</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply	0 830		

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0 830	<p>Continued From page 14</p> <p>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for the licensee's one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>On February 9, 2026, at 10:00 a.m., the nurse evaluator entered the licensee facility and noticed a strong smell of cigarette smoke throughout the house. Clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated R1 was recently diagnosed with renal failure has experienced increased weakness and fatigue. Due to the fatigue and weakness, R1 has been</p>	0 830		
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0 830	<p>Continued From page 15</p> <p>vaping in the house. He tells staff that he is tired and doesn't have the energy to go outside to the smoking area, so will vape inside. He is repeatedly encouraged to go outside, but states he doesn't have the energy. LALD/CNS-A stated R1 was moved from a bedroom on the second floor to a first floor bedroom, due to weakness, and to make it easier to go outside to smoke. R1 will go outside at times, but will still vape in his room. Staff continue to monitor and encourage him to smoke in the designated smoking area.</p> <p>R1 was admitted on July 18, 2025, with a diagnoses including hypertension.</p> <p>R1's Care Plan dated October 17, 2025, indicated services to include medication reminders, prescription management and appointment scheduling by the registered nurse. A safe smoking evaluation was completed, which indicted R1 was independent and safe to smoke outside in the designated smoking area.</p> <p>A change of condition assessment completed on January 7, 2026, indicated R1 was sent to the hospital and diagnosed with renal failure, diabetes, and low hemoglobin. The assessment documented the resident is legally blind and is prone to falls. R1 was moved from a second floor bedroom to the first floor to prevent falls. The assessment lacked information on safe smoking.</p> <p>On February 10, 2026, at 9:00 a.m., LALD/CNS-A stated R1 doesn't smoke in the house, but will vape. R1 was recently moved from a second floor bedroom to a first floor bedroom, due to increased weakness. Over the last couple of weeks, licensee employees need to repeatedly remind R1 to go outside to smoke/vape. He will go outside periodically, but sometimes states he</p>	0 830		

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0 830	<p>Continued From page 16</p> <p>is too tired to go outside to the smoking area, and will vape in his room.</p> <p>R1's Resident Contract for Assisted Living dated July 18, 2025, indicated residents are "not to smoke in the Apartment/Room or elsewhere on the Community's premises unless otherwise designated by the Community and not engage in smoking conduct that endangers people or property, even in designated areas."</p> <p>The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics.</p> <p>Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 830		
0 900 SS=F	<p>144G.50 Subdivision 1 Contract required</p> <p>(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written</p>	0 900		

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0 900	<p>Continued From page 17</p> <p>contract with the resident.</p> <p>(b) The contract must contain all the terms concerning the provision of:</p> <p>(1) housing;</p> <p>(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and</p> <p>(3) the resident's service plan, if applicable.</p> <p>(c) A facility must:</p> <p>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and</p> <p>(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.</p> <p>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.</p> <p>(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.</p> <p>(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content for the licensee's one resident (R1).</p> <p>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</p>	0 900		

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0 900	<p>Continued From page 18</p> <p>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).</p> <p>The findings include:</p> <p>The licensee failed to execute a written Assisted Living contract to include the signature of the resident prior to providing housing or assisted living services.</p> <p>R1 was admitted on July 18, 2025, with diagnoses including hypertension.</p> <p>R1's Care Plan dated October 17, 2025, indicated services to include medication reminders, prescription management and appointment scheduling by the registered nurse</p> <p>R1's Resident Contract for Assisted Living dated July 18, 2025, lacked a signature by R1 to verify agreement with the content of the contract.</p> <p>On February 10, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A verified R1's contract lacked R1's signature. LALD/CNS-A stated she is aware of the requirement, but stated R1 refused to sign the contract, and stated she did not indicate the reason R1 refused to sign the contract.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 900		

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0 910	Continued From page 19	0 910		
0 910 SS=C	<p>144G.50 Subd. 2 (a-b) Contract information</p> <p>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.</p> <p>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:</p> <p>(1) the facility and contracted service provider when applicable;</p> <p>(2) the licensee of the facility;</p> <p>(3) the managing agent of the facility, if applicable; and</p> <p>(4) the authorized agent for the facility.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents.</p> <p>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).</p> <p>The findings include:</p> <p>On February 9, 2026, at 10:00 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A provided a copy of the licensee's assisted living contract. The contract did not contain the licensee's health facility identification number (HFID) as required.</p>	0 910		

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0 910	<p>Continued From page 20</p> <p>On February 10, 2026, at 11:30 a.m., CNS/LALD-A verified the licensee's contract lacked the HFID number and verified the contract was provided to all licensee residents upon admission. CNS/LALD-A stated she was not aware of the requirement.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 910		
0 950 SS=F	<p>144G.50 Subd. 3 Designation of representative</p> <p>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:</p> <p>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.</p> <p>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."</p> <p>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a</p>	0 950		

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0 950	<p>Continued From page 21</p> <p>designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to identify a designated representative for the licensee's one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1 was admitted to the facility on July 18, 2025, with diagnoses including hypertension.</p> <p>R1's Care Plan dated October 17, 2025, indicated R1 received services to include medication reminders, prescription management and appointment scheduling by the registered nurse.</p> <p>R1's unsigned contract dated July 18, 2025, included a line to document the resident's designated representative, but lacked documentation of the name of the designated representative, or documentation the resident refused to name a designated representative. The contract also lacked the following verbatim</p>	0 950		
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0 950	<p>Continued From page 22</p> <p>notice on a document separate from the contract:</p> <p>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."</p> <p>On February 10, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee's contract lacked documentation of the above required notice, and verified R1's contract lacked documentation of a designated representative or refusal to name a designated representative.</p> <p>The licensee's June 2021, Designated Representative form verified the above right to designate a representative language and included the right to choose or decline to choose a representative.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 950		
01640 SS=F	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living</p>	01640		

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01640	<p>Continued From page 23</p> <p>facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee to document agreement on the services to be provided for the licensee's one resident (R1).</p> <p>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).</p>	01640		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38736	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2026
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NAME OF PROVIDER OR SUPPLIER HOPE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8035 STEVENS AVENUE SOUTH BLOOMINGTON, MN 55420
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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	<p>Continued From page 24</p> <p>The findings include:</p> <p>R1 was admitted on July 18, 2025, with a diagnoses including hypertension.</p> <p>R1's Service Plan dated August 1, 2025, indicated services to include medication assistance, safety checks, and behavior management.</p> <p>On February 10, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated R1's service plan was not signed by the resident or licensee representative. CNS/LALD-A stated R1 refused to sign the service plan and stated she did not document why R1 refused to sign the service plan.</p> <p>The licensee's Service Plan policy dated August 1, 2023, indicated the service plan and any revisions shall include a signature or other authentication by the resident, or resident's representative, documenting agreement on the services to be provided.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01640		



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	License Info	Inspection Info
<p>Hope Homes LLC 8035 Stevens Avenue South Bloomington, MN 55420 Hennepin County Parcel: Phone:</p>	<p>License: HFID 38736 Risk: License: Expires on: CFPM: Ali F. Egal CFPM #: 63664; Exp: 12/03/2028</p>	<p>Report Number: F1021261039 Inspection Type: Full - Single Date: 2/10/2026 Time: 10:32:24 AM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 1</u> <u>Total Priority 3 Orders: 3</u> <u>Delivery: Emailed</u></p>

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN RESIDENTIAL DISH MACHINE. PROVIDE ONE THERMOLABEL LEFT ON-SITE. SEE COMMENTS.

Comply By: 2/10/2026 Originally Issued On: 2/10/2026

New Order: 4-500 Equipment Maintenance and Operation

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: ESTABLISHMENT HAS A FOOD THERMOMETER ON-SITE BUT THE BATTERY IS DEAD. STAFF WILL REPLACE THE BATTERY SO THE THERMOMETER WORKS.

Comply By: 2/12/2026 Originally Issued On: 2/10/2026

New Order: 4-600 Cleaning Equipment and Utensils

4-601.11C *Priority Level: Priority 3 CFP#: 49*

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

COMMENT: THE STOVE HOOD VENTILATION FILTER IS COVERED WITH GREASE ACCUMULATION. CLEAN AND MAINTAIN CLEAN.

Comply By: 2/13/2026 Originally Issued On: 2/10/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.14A *Priority Level: Priority 3 CFP#: 10*

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: HANDWASHING SINK IN THE BASEMENT EMPLOYEE BATHROOM IS MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 2/11/2026 Originally Issued On: 2/10/2026

Food & Beverage General Comment

All findings on this report were discussed with LALD, Fardous Egal and Health Regulation Division Nurse Evaluator, Jolene Bertelsen.

This facility is a residential home, and they currently have 1 client and the facility can accommodate up to 5 clients.

Food is for same-day service. Leftovers are discarded at the end of service.

The kitchen has residential equipment and residential physical facilities. Residential physical facility items will be monitored during future inspections.

A temperature indicator (thermolabel) was left on-site to verify that the residential dishwasher achieves a utensil surface temperature of 160F or higher. Staff will e-mail inspector a photo of the thermolabel.

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 F1021261039 from 2/10/2026

Melissa Ramos

Fardous Egal
LALD

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us



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

Temperature Observations/Recordings

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Establishment Info

Hope Homes LLC
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1021261039
Inspection Type: Full
Date: 2/10/2026
Time: 10:32:24 AM

Food Temperature: Product/Item/Unit: Yogurt ; **Temperature Process:** Cold-Holding

Location: Kitchen Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk ; **Temperature Process:** Cold-Holding

Location: Kitchen Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Kitchen Refrigerator ; **Temperature Process:** Ambient Air

Location: Kitchen Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL38736016-0	Date: 2/11/2026
Facility Name: Hope Homes	
Facility Address: 8035 Stevens Ave. S, Minneapolis, MN 55420	

TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Required egress window openings in rooms of care facilities licensed or registered by the state of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.2, 1104.26.6.1]

Comments: LALD/CNS-A opened the window in bedroom one for measurement. The window measured 22.5 inches in height and 27.5 inches in width. The clear opening area was 618.75 square inches. The window did not meet the minimum clear opening requirement.

TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: HM-B tested the hardwired alarm on the second floor and the hardwired alarms on the main floor hallway and basement mechanical room sounded but no other alarms sounded. HM-B tested a battery powered alarm on the main floor and all other battery powered alarms sounded but none of the hardwired alarms sounded. All smoke alarms, including existing hardwired alarms, must be interconnected.

TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: There was no evacuation map included in the Hope Homes Fire Safety plan dated October 28, 2023. There was no evacuation map posted in the basement of the facility. LALD/CNS-A stated they did not have map for the basement level.

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

Comments: Hope Homes Fire Safety plan dated October 28, 2023, was an unedited third party written policy. The plan had not been updated to include specific employee actions to be taken in the event of fire or similar emergency at this facility.

3. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: LALD/CNS-A provided the surveyor with fire drill logs for calendar year 2025. The logs listed six fire drills that had been conducted but all the drills were marked a.m. day shift. No drills were documented for the swing shift or night shift. No drills were documented in January, February, October or November. The drills logs failed to show that fire drills were conducted every other month and that each shift had participated in at least two drills.