



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 2, 2026

Licensee

Dis-Generation Group Inc
9032 Prestwick Parkway
Brooklyn Center, MN 55443

RE: Project Number(s) SL37713016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 2, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37713	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2026
NAME OF PROVIDER OR SUPPLIER DIS-GENERATION GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9032 PRESTWICK PARKWAY BROOKLYN CENTER, MN 55443		
(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: SL37713016-0 On August 31, 2026, through September 2, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510			

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

TITLE

(X6) DATE

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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 August 31, 2026, at 12:40 p.m., the surveyor requested to review the licensee's infection prevention and control program. Licensed assisted living director (LALD)-A provided the surveyor with the licensee's infection control	0 510			

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0 510	Continued From page 2 policy. The licensee lacked an infection control program with the following content: - demonstration of leadership support; - education and training; - resident, family, and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. On August 31, 2026, at 2:00 p.m., LALD-A stated they were unaware of the written infection control program requirement. The licensee's undated Infection Control policy indicated the licensee will observe the recommended precautions for assisted living as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those residents with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control. The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated Core Practices should be implemented in all settings where healthcare is delivered including: - leadership support; - education and training on infection prevention; - resident, family and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions.	0 510			

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0 510	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
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 interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included annual facility TB risk assessment. In addition, the licensee failed to complete TB screening for one of three employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a	0 660			

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0 660	Continued From page 4 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: The facility TB risk assessment dated March 9, 2024, indicated the facility was at a low risk for TB transmission. The licensee lacked a facility TB risk assessment completed annually. ULP-C started employment with the licensee on October 14, 2021, to provide assisted living services. ULP-C's record included a chest Xray (CXR) done on October 25, 2021. ULP-C's record lacked a TB history and symptom screen and a positive TB result before doing a CXR. On September 2, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-F stated they thought they had completed annual TB facility risk assessment. CNS-F also stated they were aware of the requirement to have a positive TB test before doing CXR. CNS-F stated they audited their employees' records, but they may have missed ULP-C's record. The licensee's undated Tuberculosis Screening policy indicated the licensee will establish and	0 660			

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0 660	Continued From page 5 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 (MMWR). The Minnesota Department of Heath's Assisted Living Frequently Asked Questions (FAQs): Staff Requirements dated June 5, 2026, indicated each provider licensed by MDH is required to complete a TB risk assessment annually. The FAQs also indicated CXR alone is not acceptable documentation. You either need documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and a CXR with provider evaluation after that date or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. The FAQs also indicated Baseline TB screening includes assessing current symptoms of active TB disease, assessing TB history, and testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680			

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0 680	Continued From page 6 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 have a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680			

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0 680	Continued From page 7 The findings include: On August 31, 2026, at 12:45 p.m., the surveyor reviewed the licensee's EPP dated March 7, 2026, and the following content was missing: - EPP program patient population; - policies and procedures for medical documents; - names and contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - LTC family notifications. On September 2, 2026, at 11:00 a.m., licensed assisted living director (LALD)-A stated they had updated their EPP and thought they had included all required content. The licensee's undated Emergency Preparedness Evacuation policy indicated the facility will establish and maintain guidelines in planning for the evacuation of residents and the facility's office as a component of their emergency preparedness program. This is to prepare with a goal of enduring safety and mitigate harm to residents and the staff. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types.	0 680			

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0 680	Continued From page 8 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 R1 was admitted to the licensee on November 20, 2025, to receive assisted living services.	0 700			

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0 700	Continued From page 9 R1's Service Plan dated August 31, 2026, indicated R1 received the following services: ambulation, grooming, housekeeping, laundry, linen change, meal tray, medication administration, medication setup, blood glucose, safety check, shopping assistance, snack, and monitoring and assessments. On September 1, 2026, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare and check R1's medications against the electronic medication administration record (eMAR) then dispense them into medication cup before administering them to R1. On September 1, 2026, at 8:22 a.m., ULP-B left the computer screen on with R1's information displayed and went downstairs to assist R1 get ready for breakfast. R2 R2 was admitted to the licensee on November 10, 2023, to receive assisted living services. R2's Service Plan dated July 15, 2024, indicated R2 received the following services: bowel movement, ambulation, bathing assistance, grooming, housekeeping, laundry, linen change, meal tray, medication administration, medication setup, shopping assistance, snack, safety check, socialization, and monitoring and assessments. On September 1, 2026, at 8:25 a.m., the surveyor observed ULP-B prepare and check R2's medications against the eMAR then dispense them into medication cup before administering them to R2. On September 1, 2026, at 8:29 a.m., ULP-B left	0 700			

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0 700	Continued From page 10 the computer screen on with R2's information displayed and went downstairs to administer R2's medications. R3 R3 was admitted to the licensee on January 27, 2023, to receive assisted living services. R3's Service Plan (Waiver) - Addendum to Contract dated February 9, 2024, indicated R3 received the following services: blood sugar monitoring, housekeeping, laundry, linen change, meal tray, medication administration, medication setup, shopping assistance, monitoring and assessments, and snack. On September 1, 2026, at 8:34 a.m., the surveyor observed ULP-B prepare and check R3's medications against the eMAR then dispense them into medication cup before administering them to R3. On September 1, 2026, at 8:38 a.m., ULP-B left the computer screen on with R3's information displayed and went downstairs to assist R3 get ready for breakfast. On September 1, 2026, at 10:00 a.m., when the surveyor asked ULP-B about residents' information displayed on the screen whenever ULP-B went to another task, ULP-B stated there was no one in the living room. On September 2, 2026, at 11:20 a.m., clinical nurse supervisor (CNS)-F stated all employees are trained on resident information confidentiality. CNS-F also stated ULP-B should have been minimizing the screen if they were returning to continue using it.	0 700			

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0 700	Continued From page 11 The licensee's undated Resident Record - Access & Storage policy indicated information in the resident record is confidential and all staff are responsible to make sure confidentiality is maintained for all resident records and information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of 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;	0 780			

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NAME OF PROVIDER OR SUPPLIER DIS-GENERATION GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9032 PRESTWICK PARKWAY BROOKLYN CENTER, MN 55443		
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0 780	Continued From page 12 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 September 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 780			
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and	01330			

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01330	Continued From page 13 demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-E). 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: ULP-B ULP-B started employment with the licensee on	01330			

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01330	Continued From page 14 August 8, 2022, to provide assisted living services. On September 1, 2026, between 8:00 a.m., and 8:36 a.m., the surveyor observed ULP-B administer medications to the licensee's residents. ULP-B's training record lacked documentation of training and competency evaluations in the following areas: Training - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - awareness of confidentiality and privacy; - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. Competency - standby assistance techniques and how to perform them. ULP-C ULP-C started employment with the licensee on October 14, 2021, to provide assisted living services. ULP-C's training record lacked documentation of training and competency evaluations in the following areas: Training - documentation requirements for all services	01330			

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01330	Continued From page 15 provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. Competency - standby assistance techniques and how to perform them. ULP-E ULP-E started employment with the licensee on April 10, 2026, to provide assisted living services. ULP-E's training record lacked documentation of training and competency evaluations in the following areas: Competency - standby assistance techniques and how to perform them. On September 2, 2026, at 10:50 a.m., clinical nurse supervisor (CNS)-F stated they had assigned all their employees the required training and completed competency training. CNS-F also stated their training software (Residex) changed sometime back adding more training and that the employees who were employed with licensee before the change happened may have missed	01330			

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01330	Continued From page 16 some required training. CNS-F also stated they had not audited the employees' records to ensure all training and competency were completed. The licensee's Orientation and Training - Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of the licensee delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470			

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01470	Continued From page 17 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470			

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01470	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation training prior to providing services, for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-E). 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: ULP-B ULP-B started employment with the licensee on August 8, 2022, to provide assisted living services. On September 1, 2026, between 8:00 a.m., and 8:36 a.m., the surveyor observed ULP-B administer medications to the licensee's residents. ULP-B's My Transcript dated October 16, 2022, indicated ULP-B had completed orientation in the following topics: - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors;	01470			

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01470	Continued From page 19 - Assisted Living Bill of Rights; and - principles of person-centered planning/service delivery. ULP-B's record lacked documentation of the following required orientation: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-C ULP-C started employment with the licensee on October 14, 2021, to provide assisted living services. ULP-C's My Transcript dated January 28, 2022, indicated ULP-C had completed orientation in the following topics: - handling emergencies and using emergency services; - Assisted Living Bill of Rights; and - principles of person-centered planning/service delivery. ULP-C's record lacked documentation of the following required orientation: - overview of Assisted Living statutes; - review of provider's policies and procedures; - reporting maltreatment of vulnerable adults or minors; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - review of types of Assisted Living services the employee will provide and provider's scope of	01470			

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01470	Continued From page 20 license. ULP-E ULP-E started employment with the licensee on April 10, 2026, to provide assisted living services. ULP-E's My Transcript dated May 5, 2026, indicated ULP-E had completed orientation in the following topics: - overview of Assisted Living statutes; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - principles of person-centered planning/service delivery. ULP-E's record lacked documentation of the following required orientation: - review of provider's policies and procedures; and - review of types of Assisted Living services the employee will provide and provider's scope of license. On September 2, 2026, at 10:50 a.m., clinical nurse supervisor (CNS)-F stated they had assigned all their employees the required training and completed competency training. CNS-F also stated their training software (Residex) changed sometime back adding more training and that the employees who were employed with licensee before the change happened may have missed some required training. CNS-F also stated they had not audited the employees' records to ensure all training and competency were completed.	01470			

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01470	Continued From page 21 The licensee's Staff Orientation and Education policy dated December 1, 2025, indicated all staff providing assisted living through the licensee will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. The policy also indicated the missing orientation training topics will be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500			

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01500	Continued From page 22 (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment in the required	01500			

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01500	Continued From page 23 annual training topics for two of three employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B started employment with the licensee on August 8, 2022, to provide assisted living services. On September 1, 2026, between 8:00 a.m., and 8:36 a.m., the surveyor observed ULP-B administer medications to the licensee's residents. ULP-B's My Transcript dated February 7, 2026, indicated ULP-B had completed annual training in the following topics for a total of 4.75 hours: - Assisted Living Bill of Rights - 0.75 hours; - infection control techniques - 1 hour; - dementia training - 2 hours; and - mental illness and de-escalation training - 1 hour. ULP-B's transcript lacked the following annual training topic(s): - reporting maltreatment of vulnerable adults or minors; - effective approaches to use to solve problems	01500			

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01500	Continued From page 24 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. ULP-C ULP-C started employment with the licensee on October 14, 2021, to provide assisted living services. ULP-C's My Transcript dated February 17, 2026, indicated ULP-C had completed 1.75 hours of annual training in the following topic: - mental illness and de-escalation training - 1.75 hours. ULP-C's annual training record lacked the following required annual training topics: - Assisted Living Bill of Rights; - infection control techniques; - reporting maltreatment of vulnerable adults or minors; - effective approaches to use to solve problems when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery; and - dementia training. On September 2, 2026, at 11:10 a.m., clinical nurse supervisor (CNS)-F stated they had assigned the required annual training topics.	01500			

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01500	Continued From page 25 CNS-F also stated they had not completed an employee record audit to ensure they had completed the assigned annual training topics. CNS-F also stated they were not aware of some of the missing annual training topics. The licensee's undated Annual Required Staff Training policy indicated all staff that perform direct care services at the licensee will complete at least eight (8) hours of annual training for each 12 months of employment. The policy also included all the topics above except for effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders, dementia training, and mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37713	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2026
NAME OF PROVIDER OR SUPPLIER DIS-GENERATION GROUP INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9032 PRESTWICK PARKWAY BROOKLYN CENTER, MN 55443		
(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
01620	Continued From page 26 the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01620			

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01620	Continued From page 27 review, the licensee failed to ensure the registered nurse (RN) conducted resident reassessment and monitoring at least every 90 calendar days for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 R1 was admitted to the licensee on November 20, 2025, to receive assisted living services. R1's Service Plan dated August 31, 2026, indicated R1 received the following services: ambulation, grooming, housekeeping, laundry, linen change, meal tray, medication administration, medication setup, blood glucose, safety check, shopping assistance, snack, and monitoring and assessments. R1's record included Assessments (90-day) completed on December 3, 2025, March 3, 2026, and June 2, 2026. The assessment dated June 2, 2026, was completed 1 day late. On September 1, 2026, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare and check R1's medications against the electronic medication administration record (eMAR) then dispense them into medication cup	01620			

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01620	Continued From page 28 before administering them to R1. R2 R2 was admitted to the licensee on November 10, 2023, to receive assisted living services. R2 Service Plan dated July 15, 2024, indicated R2 received the following services: bowel movement, ambulation, bathing assistance, grooming, housekeeping, laundry, linen change, meal tray, medication administration, medication setup, shopping assistance, snack, safety check, socialization, and monitoring and assessments. R2's record included Assessments (90-day) completed on November 8, 2025, February 7, 2026, May 12, 2026, and August 11, 2026. The assessment dated February 7, 2026, was completed 1 day late, the assessment completed May 12, 2026, was completed 4 days late, and the assessment completed August 11, 2026, was completed 1 day late. On September 1, 2026, at 8:25 a.m., the surveyor observed ULP-B prepare and check R2's medications against the eMAR then dispense them into medication cup before administering them to R2. R3 R3 was admitted to the licensee on January 27, 2023, to receive assisted living services. R3's Service Plan (Waiver) - Addendum to Contract dated February 9, 2024, indicated R3 received the following services: blood sugar monitoring, housekeeping, laundry, linen change, meal tray, medication administration, medication setup, shopping assistance, monitoring and assessments, and snack.	01620			

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01620	Continued From page 29 R3's record included Assessments (90-day) completed on February 16, 2026, May 15, 2026, and August 14, 2026. The assessment dated August 14, 2026, was completed 1 day late. On September 1, 2026, at 8:34 a.m., the surveyor observed ULP-B prepare and check R3's medications against the eMAR then dispense them into medication cup before administering them to R3. On September 2, 2026, at 11:20 a.m., clinical nurse supervisor (CNS)-F stated they used Residex (documentation system) to schedule their assessments. CNS-F also stated they scheduled their assessment on the 90th day to meet the statute requirement. CNS-F also stated the assessments that were completed late fell on the weekend most of the time. However, CNS-F stated they were available over the weekend to attend any emergencies. The licensee's undated Assessments, Reviews & Monitoring policy indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section	01820			

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01820	Continued From page 30 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of three 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: R2 was admitted to the licensee on November 10, 2023, to receive assisted living services. R2's diagnoses included schizophrenia, change in mental status, mild neurocognitive disorder, permanent arterial fibrillation, psychosis, and severe major depression without psychotic features. R2's Service Plan dated July 15, 2024, indicated R2 received the following services medication administration, medication set up, bowel movement, ambulation, bathing assistance, grooming, housekeeping, laundry, linen change, meal tray, shopping assistance, snack, safety check, socialization, and monitoring and assessments.	01820			

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01820	Continued From page 31 R2's medication administration record (MAR) dated August 2026, indicated R2 was taking the following medications bupropion give 150 milligram (mg) tablet by mouth once daily, docusate 100 mg give one capsule by mouth twice daily, polyethylene glycol mix 17 gram (g) of white powder with 8 ounce (oz) of liquid and drink by mouth daily at daily, aripiprazole 5 mg give one tablet by mouth daily, duloxetine HCL 20 mg give one capsule by mouth daily, and Eliquis 5 mg give 1 tablet by mouth twice daily. R2's record lacked signed prescriber's orders for all the medications the licensee managed for R2. On September 1, 2026, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare and check R2's medications against the eMAR then dispense them into medication cup before administering them to R2. On September 2, 2026, at 11:20 a.m., clinical nurse supervisor (CNS)-F stated they had an after-visit summary with all the medications R2 was taking. When the surveyor and CNS-F went through the after-visit paperwork it was not signed electronically or by hand by the provider. The licensee's undated Medication & Treatment Orders policy indicated to ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01820			

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01820	Continued From page 32 days	01820			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01940			

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01940	Continued From page 33 licensee failed to develop and implement a current treatment or therapy management plan (TTMP) to include all required content for two of two resident (R1, R3) who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on November 20, 2025, to receive assisted living services. R1's Service Plan dated August 31, 2026, indicated R1 received the following services: ambulation, grooming, housekeeping, laundry, linen change, meal tray, medication administration, medication setup, blood glucose, safety check, shopping assistance, snack, and monitoring and assessments. R1's Resident Vitals - Blood Glucose dated August 1, 2026, through September 1, 2026, indicated R1's blood glucose ranged between 84 milligrams per deciliter (mg/dL) - 234 mg/dL. R3 R3 was admitted to the licensee on January 27, 2023, to receive assisted living services. R3's Service Plan (Waiver) - Addendum to	01940			

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01940	Continued From page 34 Contract dated February 9, 2024, indicated R3 received the following services: blood sugar monitoring, housekeeping, laundry, linen change, meal tray, medication administration, medication setup, shopping assistance, monitoring and assessments, and snack. R3's Resident Vitals - Blood Glucose dated August 1, 2026, through September 1, 2026, indicated R3's blood glucose ranged between 107 mg/dL - 279 mg/dL. R1 and R3's record lacked a TTMP with all the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On September 2, 2026, at 11:20 a.m., clinical nurse supervisor (CNS)-F stated they were not aware of the required treatment management plan content. The licensee's undated Treatment & Therapy Management Plan policy indicated the licensee will provide treatment and therapy management services and must develop, implement, and maintain up-to-date written treatment or therapy	01940			

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01940	Continued From page 35 management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. The policy lacked verbiage for TTMP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02320 SS=F	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, the licensee failed to ensure one of one unlicensed personnel (ULP)-B followed appropriate medication administration procedures. 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	02320			

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02320	Continued From page 36 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B started employment with the licensee on August 8, 2022, to provide assisted living services. On September 1, 2026, at 8:00 a.m., the surveyor observed ULP-B wash their hands in the kitchen sink, then ULP-B pulled R1's medications from the medication cart and checked them against electronic medication administration record (eMAR) and put the medication in a medication cup then set the medication cup on the medication cart. ULP-B repeated the same procedure for R2 and R3's medications and set all the three medication cups on the medication cart. On September 1, 2026, at 8:22 a.m., ULP-B left R1 and R2's medications on the medication cart unattended as ULP-B went to administer R3's medication in their room. On September 1, 2026, at 8:29 a.m., R1 came into the dining room for breakfast, before R1 could start eating ULP-B handed R1 their medications in a medication cup and ULP-B left for another task before R1 took their medications. R2's medication were still on the medication cart unattended. On September 1, 2026, at 10:00 a.m., ULP-B stated the medication cups were labeled and that it was easier for them to pre-arrange the medications before the residents came for breakfast.	02320			

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02320	Continued From page 37 ON September 1, 2026, at 10:20 a.m., licensed assisted living director (LALD)-A stated the employees are trained to administer medications to one resident at time before starting to prepare for the next. LALD-A also stated employees are supposed to watch the resident take their medication before starting another task. The licensee's undated Medication Administration policy indicated residents of the licensee are entitled to a safe administration of medication by qualified personnel according to a written medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



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

Page: 1

Establishment Info	License Info	Inspection Info
DIS-GENERATION GROUP INC 9032 Prestwick Pkwy Brooklyn Park, MN 55443 Hennepin County Parcel: Phone:	License: HFID 37713 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F8058261201 Inspection Type: Full - Single Date: 8/31/2026 Time: 11:26:30 AM Duration: minutes Announced Inspection: No <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery: Emailed</u>

No orders were issued for this inspection report.

Food & Beverage General Comment

HRD INSPECTOR BENARD NYANGENA

160 DISH MACHINE
41 BLUE BERRY
40 CHEESE

LAMINATE FLOOR, LAMINATE COUNTER, GLASS TILE BACKSPLASH, WOOD CABINETS, PAINTED SHEET ROCK,
NON COMMERCIAL APPLIANCES

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 F8058261201 from 8/31/2026

STELLA CHIDIWMA
PIC

Aaron Gertz
Public Health Sanitarian 3
aaron.gertz@health.state.mn.us

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL37713016-0	Date: 9/1/2026
Facility Name: DIS-GENERATION GROUP INC	
Facility Address: 9032 Prestwick Pkwy N, Brooklyn Park, Minnesota 55443	

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms shall be 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: Two separate smoke alarm systems were installed, a hardwired system and a battery-powered system. Each separate system was not interconnected with all other smoke alarms in the facility. The hardwired smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms.