



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 23, 2026

Licensee

The Friendship Home Community
947 Lydia Drive West
Roseville, MN 55113

RE: Project Number(s) SL30530016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 19, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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:

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

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,



Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113		
(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: SL30530016-0 On August 17, 2026, through August 19, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were six residents; six 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.		
0 480 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

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 18, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical, and nursing standards for infection control. This 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).	0 510			

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0 510	Continued From page 4 The findings include: On August 17, 2026, at 11:30 a.m., the surveyor reviewed the licensee's undated infection control program, and the following content was missing: - resident, family and visitor education - how to provide appropriate infection prevention to residents, family members, visitors, and others. On August 17, 2026, at 2:20 p.m., licensed assisted living director (LALD)-B stated the content was missing from their infection control program. LALD-B also stated their infection control program was reviewed recently to ensure it had all the required content, so they were not sure how they missed the content identified above. The licensee's undated Infection Control policy indicated infection control practices are important to [licensee] for the health and safety of both staff, residents, and guests. The facility has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated Core Practices should be implemented in all settings where healthcare is delivered including: - leadership support; - education and training on infection prevention; - resident, family and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. No further information was provided.	0 510			

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0 510	Continued From page 5	0 510			
	TIME PERIOD FOR CORRECTION: Two (2) days				
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1, 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 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:	0 630			

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0 630	Continued From page 6 R1 R1 was admitted to the licensee on July 16, 2025, and began receiving assisted living services. R1's diagnoses included schizophrenia disorder, bipolar type, type 2 diabetes mellitus with diabetic neuropathy, unspecified, major depressive disorder, recurrent, anxiety disorder, unspecified, and cocaine use. R1's Service Plan dated July 16, 2025, indicated R1 received the following services: medication administration, nurse monitoring and assessments, housekeeping, linen change, personal laundry, blood glucose monitoring, modified diet, assistance with bathing, hair care, grooming, and toileting. R1's IAPP dated June 16, 2026, indicated R1 was susceptible to abuse from another individual including other vulnerable adults, and was at risk of self-abuse. However, R1's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults. R2 R2 was admitted to the licensee on April 4, 2016, under the former comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included Alzheimer's disease unspecified, essential hypertension, unspecified atrial fibrillation, unspecified urinary incontinence, and major depressive disorder. R2's Service Plan dated April 1, 2026, indicated R2 received the following services: medication	0 630			

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0 630	Continued From page 7 administration, nurse monitoring and assessments, housekeeping, linen change, personal laundry, modified diet, assistance with bathing, hair care, grooming, assistance with self-feeding, oral hygiene, and assistance with toileting. R2's IAPP dated May 31, 2026, indicated R2 was susceptible to abuse from another individual including other vulnerable adults. However, R2's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults. On August 19, 2026, at 1:20 p.m., licensed assisted living director (LALD)-B stated clinical nurse supervisor (CNS)-A was responsible for completing R1 and R2's IAPP assessments to include all required content. However, CNS-A was not available for interview. The licensee's Vulnerable Adult policy dated May 29, 2025, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. The policy indicated the plan would include the following: - an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults; - the risk of abusing other vulnerable adults; - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults; - the plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary; and - documentation will include results of the implementation.	0 630			

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0 630	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the	0 680			

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0 680	Continued From page 9 required content. This had the potential to affect all residents receiving services under the provisional assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated January 1, 2026, lacked the following required content: - EPP resident population; - policies and procedures for subsistence needs for staff and residents; - policies and procedures for tracking of staff; - policies and procedures for arrangements with other facilities; - primary and alternate means for communication; and - long term care family notifications. On August 17, 2026, at 2:20 p.m., licensed assisted living director (LALD)-B stated the licensee reviewed and updated their EPP to be compliant with state requirements, and did not expect their EPP to be missing content. After the surveyor reviewed the licensee's EPP with LALD-B, they stated their EPP was still missing content that they will need to include. The licensee's Emergency Preparedness - Appendix Z Compliance policy dated May 15, 2025, indicated it is the intent that [licensee] has	0 680			

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0 680	Continued From page 10 in place an effective and compliant Emergency Preparedness Plan. The plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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	0 780			

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0 780	Continued From page 11 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; 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	0 780			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113		
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0 780	Continued From page 12 August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	0 800			

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0 800	Continued From page 13 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
01330 SS=E	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 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 areas, prior to providing services, for two	01330			

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NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113		
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01330	Continued From page 14 of three employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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-C ULP-C started employment with the licensee on September 28, 2020, under the former comprehensive license and started to provide assisted living services on August 1, 2021. On August 18, 2026, from 7:36 a.m., through 8:53 a.m., the surveyor observed ULP-C administer medications to the licensee's residents. ULP-C's record lacked the following required training before providing assisted living services: Training - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and Competency - range of motioning and positioning. ULP-D ULP-D started employment with the licensee on	01330			

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01330	Continued From page 15 March 9, 2026, to provide assisted living services. ULP-D's record lacked the following required training before providing assisted living services: Training - 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. On August 17, 2026, at 2:45 p.m., licensed assisted living director/owner (LALD/O)-F stated all employees are assigned assisted living training topics from Educare (training software) and were expected to complete it before starting to provide assisted living services. When the surveyor asked how the licensee ensured training was completed as assigned, LALD/O-F stated clinical nurse supervisor (CNS)-A was responsible for completing record audits. However, CNS-A was not available for interview. The licensee's Employee General Orientation policy dated August 1, 2021, indicated upon hire and prior to performing any functions of their position at the [licensee], each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. The policy lacked verbiage to include required training and competency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			

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01470	Continued From page 16	01470			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470			

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01470	Continued From page 17 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. 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)-C), ULP-D, licensed practical nurse (LPN)-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).	01470			

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01470	Continued From page 18 The findings include: ULP-C ULP-C started employment with the licensee on September 28, 2020, under the former comprehensive license and started to provide assisted living services on August 1, 2021. On August 18, 2026, from 7:36 a.m., through 8:53 a.m., the surveyor observed ULP-C administer medications to the licensee's residents. ULP-C's My Transcript dated April 28, 2021, indicated ULP-C completed the following orientation training: - overview of Assisted Living statutes; - review of provider's policies and procedures; - 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-C's record lacked the following required orientation topic: - review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-D ULP-D started employment with the licensee on March 9, 2026, to provide assisted living services. ULP-D's My Transcript dated July 26, 2026, indicated ULP-D completed the following	01470			

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01470	Continued From page 19 orientation training: - overview of Assisted Living statutes; - review of provider's policies and procedures; - 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; and - consumer advocacy services; ULP-D's record lacked the following required orientation topics: - review of types of Assisted Living services the employee will provide and provider's scope of license; and - principles of person-centered planning/service delivery. LPN-E LPN-E started employment with the licensee on April 12, 2022, to provide assisted living services. LPN-E's My Transcript March 3, 2024, indicated LPN-E completed the following orientation training: - overview of Assisted Living statutes; - review of provider's policies and procedures; - 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.	01470			

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01470	Continued From page 20 LPN-E's record lacked the following required orientation topic: - review of types of Assisted Living services the employee will provide and provider's scope of license. On August 17, 2026, at 2:45 p.m., licensed assisted living director/owner (LALD/O)-F stated all employees are assigned assisted living training topics from Educare (training software) and were expected to complete it before starting to provide assisted living services. When the surveyor asked how the licensee ensured training was completed, LALD/O-F stated clinical nurse supervisor (CNS)-A was responsible for completing record audits. However, CNS-A was not available for interview. LALD/O-F also stated they would provide their training material to prove the missing topics were covered, however, LALD/O-F did not provide any additional information. The licensee's Employee General Orientation policy dated August 1, 2021, indicated upon hire and prior to performing any functions of their position at the [licensee], each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. The policy lacked verbiage to include required orientation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620			

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01620	Continued From page 21 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse 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	01620			

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01620	Continued From page 22 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted resident reassessment and monitoring at least every 90 calendar days for 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 July 16, 2025, and began receiving assisted living services. R1's Service Plan dated July 16, 2025, indicated R1 received the following services: medication administration, nurse monitoring and assessments, housekeeping, linen change, personal laundry, blood glucose monitoring,	01620			

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01620	Continued From page 23 modified diet, assistance with bathing, hair care, grooming, and toileting. On August 18, 2026, at 8:53 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1 in their room. R1's record included three nursing assessments which the registered nurse started on a different date and signed completed days later as follows: assessment started on December 3, 2025, was signed and dated on April 5, 2026, 123 days later, assessment started on March 3, 2026, was signed and dated on April 5, 2026, 33 days later, assessment started on June 1, 2026, was signed and dated on June 16, 2026, 15 days later. R2 R2 was admitted to the licensee on April 4, 2016, under the former comprehensive license and began receiving assisted living services on August 1, 2021. R2's Service Plan dated April 1, 2026, indicated R2 received the following services: medication administration, nurse monitoring and assessments, housekeeping, linen change, personal laundry, modified diet, assistance with bathing, hair care, grooming, assistance with self-feeding, oral hygiene, and assistance with toileting. On August 18, 2026, at 7:36 a.m., the surveyor observed ULP-C administer medications to R2 in the dining room area. R2's record included three nursing assessments which the registered nurse started on a different date and signed completed days later as follows: assessment started on January 15, 2026, was	01620			

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01620	Continued From page 24 signed and dated on April 26, 2026, 101 days later, assessment started on March 6, 2026, was signed and dated on March 12, 2026, 6 days later, assessment started on June 4, 2026, was signed and dated on July 26, 2026, 52 days later. R3 R3 was admitted to the licensee on September 5, 2024, and began receiving assisted living services. R3's Service Plan dated September 5, 2025, indicated R3 received the following services: medication administration, nurse monitoring and assessments, housekeeping, linen change, personal laundry, blood glucose monitoring, assistance with dressing, assistance with bathing, hair care, grooming, and toileting. On August 18, 2026, at 7:52 a.m., the surveyor observed ULP-C administer medications to R3 in their room. R3's record included three nursing assessments which the registered nurse started on a different date and signed completed days later as follows: assessment started on December 24, 2025, was signed and dated on May 31, 2026, 158 days later, assessment started on March 24, 2026, was signed and dated on April 5, 2026, 12 days later, assessment started on May 28, 2026, was signed and dated on July 26, 2026, 59 days later. On August 19, 2026, at 2:35 p.m., licensed assisted living director/owner (LALD/O)-F stated they thought it did not matter the date the assessment was signed completed if it was started within the 90-day window. LALD/O-F also stated this was a RN question; however clinical nurse supervisor (CNS)-A was available for	01620			

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01620	Continued From page 25 interview. The licensee's Uniform Assessment Tool policy dated May 29, 2025, indicated [licensee] will use a uniform assessment tool that addresses all the required elements. The policy lacked the verbiage to include resident reassessment and monitoring at least every 90 calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113		
(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
01650	Continued From page 26 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for two of three residents (R1, 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 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: R1 R1 was admitted to the licensee on July 16, 2025, and began receiving assisted living services. R1's Service Plan dated July 16, 2025, indicated R1 received the following services: medication administration, nurse monitoring and assessments, housekeeping, linen change, personal laundry, blood glucose monitoring, modified diet, assistance with bathing, hair care, grooming, and toileting. On August 18, 2026, at 8:53 a.m., the surveyor	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113		
(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
01650	Continued From page 27 observed unlicensed personnel (ULP)-C administer medications to R1 in their room. R1's service plan lacked the following content: - the fees for services; and - identification of staff or categories of staff who will provide blood glucose. R2 R2 was admitted to the licensee on April 4, 2016, under the former comprehensive license and began receiving assisted living services on August 1, 2021. R2's Service Plan dated April 1, 2026, indicated R2 received the following services: medication administration, nurse monitoring and assessments, housekeeping, linen change, personal laundry, modified diet, assistance with bathing, hair care, grooming, assistance with self-feeding, oral hygiene, and assistance with toileting. On August 18, 2026, at 7:36 a.m., the surveyor observed ULP-C administer medications to R2 in the dining room area. R2's service plan lacked the following content: - the fees for services; - the frequency for medication reminders; and - identification of staff or categories of staff who will provide assistance with hair care. On August 19, 2026, at 2:45 p.m., licensed assisted living director/owner (LALD/O)-F stated the service plan was supposed to have all the missing content above. LALD/O-F also stated it may have been an error on the registered nurse (RN) when completing the service plan.	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113		
(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
01650	Continued From page 28 The licensee's Service Plan policy dated May 29, 2025, indicated service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. The policy also included all the missing content above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01940 SS=D	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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 29 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 licensee failed to develop and implement a current treatment or therapy management plan (TTMP) to include all required content for one of one resident (R1) who received oxygen therapy. In addition the licensee failed to include oxygen therapy in the service plan and have the parameters within which to monitor R1's oxygen. 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: R1 was admitted to the licensee on July 16, 2025, and began receiving assisted living services. R1's Service Plan dated July 16, 2025, indicated R1 received the following services: medication administration, nurse monitoring and assessments, housekeeping, linen change, personal laundry, blood glucose monitoring, modified diet, assistance with bathing, hair care,	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 30 grooming, and toileting. On August 18, 2026, at 8:53 a.m., the surveyor observed two oxygen tanks and oxygen concentrator connected with tubes in R1's room . R1's Physician Orders dated April 1, 2026, indicated oxygen 2-4 liters (l) via nasal cannula; 4 l during day if oxygen saturations are below 88%, 2 l at hours of sleep via continuous positive airway pressure (CPAP) machine, and check two times a day and as needed. R1's service plan lacked oxygen therapy as a service R1 was receiving. R1's medication administration record (MAR) dated August 2026, indicated connect R1's oxygen to the CPAP and turn the oxygen flow to 2 liters and ensure concentrator is on and tubing is not kinked. The MAR also indicated when R1 wakes up take off CPAP and turn on oxygen flow back to 4 liters and switch the oxygen over to nasal cannula. R1's record lacked the parameters within which to monitor R1's oxygen. R1's record also lacked the content of ITTMP to include: - a statement of the type of services that will be provided; - 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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 31 - 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 August 19, 2026, at 2:40 p.m., licensed assisted living director/owner (LALD/O)-F stated R1 was recently started on oxygen therapy and that the registered nurse (RN) had not updated R1's assessment and individual treatment and therapy management plan to include oxygen. The licensee's Treatment & Therapy Management Plan policy dated August 1, 2026, indicated [licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatment and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER THE FRIENDSHIP HOME COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 947 LYDIA DRIVE WEST ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01940	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	01940			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

THE FRIENDSHIP HOME COMMUNITY
947 LYDIA DRIVE WEST
Roseville, MN 55113
Ramsey County
Parcel:

Phone:

License Info

License: HFID 30530

Risk:
License:
Expires on:
CFPM: Susie Johnson
CFPM #: 28090; Exp: 09/26/2027

Inspection Info

Report Number: F1021261231
Inspection Type: Full - Single
Date: 8/18/2026 Time: 12:05:04 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-500D Microbial Control: disposition of food

3-501.18A Priority Level: Priority 1 CFP#: 23

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

COMMENT: AN OPEN BAG OF SLICED DELI MEAT WAS FOUND IN THE WHIRLPOOL KITCHEN REFRIGERATOR WITH AN OPENING DATE OF 08/10/2026. THIS DATE IS BEYOND THE ALLOWED SEVEN DAY STORAGE PERIOD FROM THE DATE OF OPENING. KITCHEN STAFF DISCARDED THE DELI MEAT DURING THE INSPECTION. CORRECTED ON-SITE.

Comply By: Complied On Site Originally Issued On: 8/18/2026

! New Order: 7-200 Toxic Supplies and Applications

7-204.11 Priority Level: Priority 1 CFP#: 28

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT: THE CHLORINE FOUND ONSITE WAS A SPLASH-LESS BLEACH, WHICH IS NOT APPROVED FOR USE ON FOOD-CONTACT SURFACES. STAFF WILL GET APPROVED STANDARD BLEACH TO USE IN THE KITCHEN.

Comply By: 8/19/2026 Originally Issued On: 8/18/2026

Food & Beverage General Comment

All findings on this report were discussed with LALD, Faiza Hassan and Health Regulation Division Nurse Evaluator, Benard Nyangena.

This facility is a residential home, and they currently have 6 clients and the facility can accommodate up to 6 clients.

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

A two basin sink is located in the kitchen. One basin is designated for hand washing.

Establishment has an NSF certified residential dishwasher. A temperature indicator was available on site to verify that the dishwasher reaches a utensil surface temperature of at least 160F. Staff will send the inspector a photo of the temperature indicator to confirm that the dishwasher is properly sanitizing.

The kitchen currently has residential equipment and residential finishes. These items will be monitored during future inspections to ensure they remain in good working condition.

Report Number: F1021261231

Inspection Type: Full

Date: 8/18/2026

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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 F1021261231 from 8/18/2026

Melissa Ramos

Faiza Hassan
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

Page: 1

Establishment Info

THE FRIENDSHIP HOME COMMUNITY
Roseville
County/Group: Ramsey County

Inspection Info

Report Number: F1021261231
Inspection Type: Full
Date: 8/18/2026
Time: 12:05:04 PM

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

Location: Whirlpool Kitchen Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Sliced Roast Beef ; **Temperature Process:** Cold-Holding

Location: Whirlpool Kitchen Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

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

Location: Kitchen at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
THE FRIENDSHIP HOME COMMUNITY	Report Number: F1021261231
Roseville	Inspection Type: Full
County/Group: Ramsey County	Date: 8/18/2026
	Time: 12:05:04 PM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Spray Bottle

Location: Kitchen **Equal To** 100 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30530016-0	Date: August 17, 2026
Facility Name: THE FRIENDSHIP HOME COMMUNITY	
Facility Address: 947 LYDIA DR W, Roseville, MN, 55113	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: In the basement outside of resident bedroom six, there wasn't a smoke alarm present.

2. 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: The main level bedroom hallway had a hard-wired alarm that was not interconnected with the battery alarms throughout the facility.

3. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

Comments: On the main level and in the basement outside resident bedroom six there was wiring for a hard-wired alarm. The alarm in the main level hallway was battery powered; the hard-wired alarm was missing from outside bedroom six.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: In the living room, there was an electrical outlet that had been broken and increased the risk of injury to residents, staff and visitors.

In the basement laundry room, the dryer duct was not connected to the dryer. Allowing combustible lint to escape and build up in the area.

In resident room four, the window crank to open the window was not attached to the window. This could cause a delay in egress during emergency situations.