Electronically Delivered

September 25, 2025

Licensee
Magnanimous Living LLC
920 Mildred Drive
Richfield, MN 55423

RE: Project Number(s) SL40912015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on July 16, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40912	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNANIMOUS LIVING LLC	920 MILDRED DRIVE RICHFIELD, MN 55423

(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: SL40912015-0 On July 14, 2025, through July 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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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,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (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, July 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. Additionally, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all residents of the facility.	0 485		

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0 485	Continued From page 4 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 14, 2025, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided the surveyor with a copy of the licensee's current contract. On July 14, 2025, at 1:45 p.m., LALD/CNS-A stated the provided contract was utilized by all residents residing within the facility. On page 5, section 3 titled "housing", listed items and services included in the monthly rent. This included the following language: "Availability of three (3) nutritious meals and two snacks per day. Additional meals may be available for purchase. Modified texture, diabetic, and heart healthy diet available." On July 14, 2025, at 1:48 p.m., LALD/CNS-A stated the licensee does currently have residents that are private pay and does not currently have an addendum available to subtract the cost of meals from the base cost of the contract. Additionally, LALD/CNS-A stated they were under the assumption they were not allowed to require residents to pay for meals, which is why they had the cost of meals included in the contract.	0 485		

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0 485	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
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 a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of two employees (registered nurse (RN)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 6 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 licensee's current TB risk assessment completed April 1, 2025, indicated a low risk level. RN-B RN-B was hired August 22, 2024, to provide clinical oversite and assisted living services. RN-B's employee record contained the following components: - A TB symptom screening dated September 5, 2024, which indicated RN-B had an allergic reaction to prior tuberculin skin tests. - A QuantiFERON TB Gold Plus test dated February 14, 2023, with a negative test result. This test occurred 569 days prior to RN-B's symptom screening, and 555 days prior to RN-B's date of hire. - A chest x-ray dated January 4, 2024, with an indication labeled "cough" with findings indicating "normal cardio mediastinal silhouette and pulmonary vasculature. Lungs are well inflated and clear. No focal consolidation, pleural infusion, or pneumothorax. No osseus abnormality. The chest x-ray occurred 245 days prior to RN-B's symptom screening dated September 5, 2024, 324 days after RN-B's negative QuantiFERON TB Gold Plus test dated February 14, 2023, and 231 days prior to RN-B's	0 660		

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0 660	Continued From page 7 hire date of August 22, 2024. RN-B's TB record was incomplete with there being no correlation between RN-B's symptom screening, QuantiFERON TB Gold test, and chest x-ray with an indication of "cough". ULP-C ULP-C was hired August 20, 2024, to provide assisted living services. ULP-C's employee record contained a TB symptom screening that lacked documentation of a completion date. On July 16, 2025, at 10:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were not aware TB screenings, testing, and subsequent x-rays needed to show documented correlations. The Minnesota department of health's, "Regulations for Tuberculosis Control in Minnesota Health Care Setting, A guide for implementing tuberculosis (TB) infection control regulations in your facility" dated July 2013 indicated the following: Before the health care worker (HCW) has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and	0 660		

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0 660	Continued From page 8 4. Medical evaluation to rule out a diagnosis of infectious TB disease. The CDC's Morbidity and Mortality Weekly Report, "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005", dated December 30, 2005, indicates the following: HCWs with a baseline positive or newly positive test result for M. tuberculosis infection (i.e., TST or BAMT) or documentation of treatment for LTBI or TB disease should receive one chest radiograph result to exclude TB disease (or an interpretable copy within a reasonable time frame, such as 6 months). Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician. The licensee's Tuberculosis Screening policy dated April 15, 2024, indicated the licensee would 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 (MMWR). Additionally, this policy indicated the following: "Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs.	0 660		

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0 660	Continued From page 9 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file." 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 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	0 680		

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0 680	Continued From page 10 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post an EPP prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On July 14, 2025, at approximately 11:15 a.m., during a tour of the facility the surveyor observed an abbreviated copy of the licensee's emergency preparedness plan posted to a wall along with the licensee's other required postings. On July 14, 2025, at 12:32 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, stated the complete EPP was stored in the lower-level nursing office. LALD/CNS-A stated the office was typically locked when not occupied and they were not aware the complete EPP needed to be posted and available.	0 680		

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0 680	Continued From page 11 In addition, the licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - arrangements with other facilities; - names and contact information of entities providing services; and - emergency official contact information. On July 16, 2025, at 12:05 p.m., LALD/CNS-A stated the licensee would post the completed EPP near the required postings board. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy, dated April 15, 2024, indicated the licensee would develop and EPP which will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix 2: "State Operations Manual Appendix Z- Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further 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.	0 700		

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0 700	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 July 15, 2025, from 8:28 a.m. to 8:46 a.m., the surveyor observed unlicensed personnel (ULP)-C leave a computer located in the licensee's dining room unlocked and unsecured after completion of documentation. The surveyor observed ULP-C leave the dining room to complete morning cares in a resident's room. This left the electronic medical record unlocked and visible to two other residents sitting in the dining room and accessible to unauthorized users. On July 15, 2025, at 8:48 a.m., ULP-C stated they were trained to secure medication rooms and computer screens when not in use. On July 16, 2025, at 12:18 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff were trained to ensure	0 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40912	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNANIMOUS LIVING LLC	920 MILDRED DRIVE RICHFIELD, MN 55423

(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
0 700	Continued From page 13 the screens were secured. The licensee's Resident Record policy dated April 15, 2024, indicated resident records will be kept confidential and locked in a secured in an area where only authorized staff will have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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	40912	A. BUILDING: _____ B. WING _____	07/16/2025

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MAGNANIMOUS LIVING LLC	920 MILDRED DRIVE RICHFIELD, MN 55423

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0 810	Continued From page 14 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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: On July 14, 2025, at approximately 12:30 p.m.., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), and evacuation drills for the facility. The licensee FSEP failed to include the following:	0 810		

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0 810	Continued From page 15 The FSEP failed to identify specific evacuation procedures for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to identify specific evacuation actions or procedures for employees. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that employees should follow in case of a fire or similar emergency. The garage was marked as an emergency exit in the FSEP, which is not appropriate for this facility as it is an area of higher hazard. During an interview on July 14, 2025, the surveyor explained the requirements for employee trainings, resident trainings, FSEP documentation, and evacuation drills. LALD/CNS-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120	01530		

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01530	Continued From page 16 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on dementia topics for one of two staff (unlicensed	01530		

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01530	Continued From page 17 personnel (ULP)-C), and two hours of initial training on mental illness for all staff. 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). ULP-C was hired August 20, 2024, to provide assisted living services. ULP-C's employee record contained evidence of completion of 7.75 hours of dementia training, indicating ULP-C had not completed the required initial 8 hours of dementia care training. Additionally, ULP-C's record lacked documentation of the required initial 2 hours of mental health training. On July 15, 2025, at 10:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that all staff were assigned mental health trainings, but they were instructed to complete the training by the end of July instead of by the beginning of July, which LALD/CNS-A stated was an oversite. The licensee's dementia training policy indicated direct care employees will complete eight hours of initial training within 160 hours of the employment start date. No further information was provided.	01530		

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01530	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	01530		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On July 15, 2025, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-C access the licensee's locked medication closet located out of direct line of site from the dining area and prepare medications for residents residing within the facility. At 8:14 a.m., after completing	01880		

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01880	Continued From page 19 preparation of medications, the surveyor observed ULP-C leave the medication closet unlocked and unsecured while administering medications within the dining room. ULP-C returned to the medication closet at 8:15 a.m., to prepare additional medications for residents. At 8:22 a.m., ULP-C again left the medication closet unlocked and unsecured while administering medication in the dining room. On July 15, 2025, at 8:48 a.m., ULP-C stated they were trained to secure medication rooms and screens when not in use. On July 16, 2025, at 12:18 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff were trained to ensure the medication room is secured when not in use. The licensee's Medication Storage policy dated April 15, 2024, indicated medications will be stored to prevent diversion of medications by residents or others who may have access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided	01910		

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01910	Continued From page 20 for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the date of disposition and names of staff and other individuals involved in the disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 discharged from the licensee on January 31, 2025.	01910		

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01910	Continued From page 21 R1's record lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On July 15, 2025, at 11:47 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the facility currently did not have any documentation or a system in place for the documentation of medication disposition. The licensee's Medication Disposal policy dated April 15, 2024, indicated upon disposition, the facility would document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of two residents (R2) who utilized bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On July 14, 2025, at 11:07 a.m., during a tour of the facility, the surveyor observed a hospital style bed with bilateral upper bed rails. Both bedrails were in the upright position. R2 was admitted September 20, 2024, to receive assisted living services. R2's diagnosis included displaced intertrochanteric fracture of left femur, Parkinson's disease without dyskinesia, anemia, neurocognitive disorder with Lewy bodies, essential hypertension, constipation, age-related osteoporosis without current pathological fracture and other specified disorders of bone density and structure. R2's service agreement dated February 13, 2025, indicated R2 received assisted living services to include physical assistance with	02310		

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02310	Continued From page 23 activities, ambulation assistance, bathing assistance, assistance with braces, safety checks, bed making, bed mobility, maintenance of CPAP device, dining assistance, oral cares, laundry, safety check of bedrails, and toileting assistance. R2's record lacked documentation that the risk vs benefits of the bed rail were discussed and documented with the resident and/or responsible party. On July 15, 2025, at 1:05 p.m., licensed assisted living director clinical nurse supervisor (LALD/CNS)-A stated they were unable to locate documentation of the risk vs benefits of bed rail usage for R2. LALD/CNS-A was able to show a risk vs benefits agreement that was utilized for another resident's bed rail. The licensee's Side rails policy dated April 15, 2024, indicated the resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided will be documented in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

Magnanimous Living LLC
920 Mildred Drive
Richfield, MN 55423
Hennepin County
Parcel:

Phone:

License Info

License: HFID 40912

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

Inspection Info

Report Number: F1005251057
Inspection Type: Full - Single
Date: 7/15/2025 Time: 11:00:58 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION COMPLETED WITH STAFF AND REVIEWED WITH HRD NURSING EVALUATOR ZACHARY MARTH.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

AN IRREVERSIBLE REGISTERING THERMOMETER WAS ON SITE AND STAFF SENT INSPECTOR A PICTURE AFTER RUNNING IT THROUGH THE DISHWASHER, SHOWING IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 167 DEGREES F.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005251057 from 7/15/2025

LAKIYANA MALI
RESIDENT SERVICE MANAGER

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Magnanimous Living LLC
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F1005251057
Inspection Type: Full
Date: 7/15/2025
Time: 11:00:58 AM

Food Temperature: Product/Item/Unit: SOUR CREAM**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HOT DOG**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 40 Degrees F.
Comment:
Violation Issued?: No

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

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

Sanitizer Observations/Recordings

Establishment Info

Magnanimous Living LLC
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F1005251057
Inspection Type: Full
Date: 7/15/2025
Time: 11:00:58 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** DISHWASHER
Location: Kitchen **Equal To** 167 Degrees F.
Comment:
Violation Issued?: No