



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 16, 2026

Licensee

Optimum Healthcare Services Limited Liability Company
5060 Hughes Avenue Northeast
Fridley, MN 55421

RE: Project Number(s) SL37263016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 12, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker', with a stylized flourish at the end.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37263	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER OPTIMUM HEALTHCARE SERVICES LL			STREET ADDRESS, CITY, STATE, ZIP CODE 5060 HUGHES AVENUE NE FRIDLEY, MN 55421		
(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: SL37263016-0 On August 10, 2026, through August 12, 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 zero (0) residents; zero receiving services under the Assisted Living Facility license. On August 12, 2026, an immediate correction order was issued for tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	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.		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff records included all required content for three of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-C, office assistant/ULP (OA/ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 650			

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0 650	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: PERFORMANCE REVIEWS CNS-A was hired July 2021 (full date unknown), to provide clinical oversight. CNS-A's Employee Job Performance Evaluation dated January 30, 2023, indicated CNS-A's hire date was January 20, 2021, and the period of evaluation was for January 2022, through January 2023. CNS-A's record lacked performance evaluations for 2024, 2025, and 2026. On August 10, 2026, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated they had not completed performance reviews since 2023, because they did not think it was required for nursing staff, only ULPs. LALD/RN-B stated performance reviews were not completed for themselves either. TRAINING RECORDS ULP-C Former employee ULP-C was hired on May 10, 2023, to provide assisted living services to residents. ULP-C's training record included the following: -Emergency preparedness and policy/procedure review May of every year between 2023 through 2025. OA/ULP-E OA/ULP-E was hired in April 2021 (full date unknown), to provide assisted living services to	0 650			

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0 650	Continued From page 3 residents. OA/ULP-E's training record included the following: -Emergency preparedness and policy/procedure review March of every year between 2021 through 2026. ULP-C and OA/ULP-E's above training included their printed first and last name but lacked the following documentation requirement: -facility name, location, and license number; -training methodology, such as classroom style, web-based training, video, or one-to-one training; -total amount of time of the training and competency evaluation; -name and title of the instructor and the instructor's signature, and the name and title of competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and -name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training document. During phone interview on August 11, 2026, at 11:50 a.m., LALD/RN-B stated annual training such as reviewing policies and procedures were completed on Educare (online training program). LALD/RN-B stated they discussed with staff about the licensee's policies and procedures and for emergency preparedness they discussed how to handle situations like severe weather or tornados. LALD/RN-B was not aware of the training documentation requirements.	0 650			

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0 650	Continued From page 4 The licensee's Personnel Records policy dated May 9, 2025, indicated personnel records for an employee would include documentation of annual performance reviews identifying areas of improvement needed and training needs. The licensee's Staff Orientation and Education policy dated August 28, 2023, indicated orientation and annual training would include instruction and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person. The licensee would maintain proof of orientation and education in the personnel files. Minnesota Administrative Rule 4659.0190, subpart 6, A., dated August 11, 2021, indicated the facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: - facility name, location, and license number; - name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; - name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and - name and title of the staff person completing the training, and the staff person's signature with a	0 650			

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0 650	Continued From page 5 statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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), to include a fully completed facility TB risk assessment, a baseline TB screening that included a two-step tuberculin (TST) skin test or other evidence of TB	0 660			

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0 660	Continued From page 6 testing such as IGRA (blood test) for two of four employees (unlicensed personnel (ULP)-C, office assistant/ULP (OA/ULP)-E). 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 the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT The licensee's Facility TB Risk Assessment dated June 2026, indicated the facility was at a low risk for TB transmission. The licensee lacked an accurate TB assessment due to the following: -incomplete date when the assessment was completed; -no identification who completed the assessment; -national rate indicated 12 per 100,000 for year 2026 (should have been 3.0 per 100,000 for year 2025; -year for Minnesota rate was left blank; -county data was left blank (Anoka County was 12 for year 2025); -categories of health care personnel included in licensee's baseline TB screening was left blank; and -date of last TB risk assessment was conducted June 2026 (cannot be same date of current assessment). TB SCREENING ULP-C	0 660			

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0 660	Continued From page 7 Former employee ULP-C was hired on May 10, 2023, to provide assisted living services to residents. ULP-C's employee record included a Baseline TB Screening Tool for Health Care Workers form (lacked a date and employee signature) and negative chest x-ray (CXR) completed on May 16, 2023, with a note indicating a positive gold test. ULP-C's record lacked documentation of a positive blood test completed prior to the CXR. During ULP-C's record review on August 10, 2026, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated they were not aware they needed documentation of a positive test prior to a CXR or documentation of refusing the TST or blood test prior to a CXR. OA/ULP-E OA/ULP-E was hired on April 2021 (full date unknown), to provide assisted living services to residents. OA/ULP-E's employee record included a Baseline TB Screening Tool for Health Care Workers form dated September 1, 2021 (approximately four months after hire date), and a negative one-step TST completed on March 26, 2021. OA/ULP-E's record lacked the required second-step TST. During phone interview on August 12, 2026, at 11:13 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated they always thought only one-step TST was needed if it was negative.	0 660			

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0 660	Continued From page 8 The licensee's Tuberculosis Screening/Prevention policy dated August 28, 2023, indicated baseline screening included either 2-step TST or blood test. If the first TST was negative, the second-step TST would be administered 1-3 weeks after the first TST result was read. Employees with an undocumented history of positive TST or blood test will undergo the same screening process as those without previous positive results. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Either test completed within 90 days of hire was acceptable. 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	0 680			

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0 680	Continued From page 9 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 develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z and post emergency exit diagrams on each floor. This had the potential to affect residents receiving services under the assisted living license, 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	0 680			

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0 680	Continued From page 10 a large portion or all of the residents). The findings include: On August 10, 2026, at 11:08 a.m., during facility tour with clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B, the surveyor observed a two-level home with a basement. There were two unoccupied bedrooms on the main level and two unoccupied rooms on the upper level. The basement included a living room, laundry room, and bathroom. While the surveyor was sitting at the kitchen table, the surveyor observed three (3) exit diagrams (one for each level) posted next to each other on the wall. The upper level and basement did not have exit diagrams posted. The licensee's EPP last reviewed on February 7, 2026, lacked the following required content: - methods for sharing information-communication plan; -training program-emergency prep training and testing-training must be site specific; and -testing requirements-emergency prep training and testing. On August 10, 2026, at 2:40 p.m., CNS-A stated they kept the EPP binder either on the table in the living room or kept it in the locked medication closet. During phone interview on August 11, 2026, at 11:50 a.m., LALD/RN-B stated they provided emergency preparedness training upon hire and annually. She explained they talked about scenarios and did drills but mostly fire drills. LALD/RN-B stated she taught staff what to do if there was severe weather or tornado and would jot down the names of staff who attended that	0 680			

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0 680	Continued From page 11 training. The surveyor requested that documentation. During phone interview on August 12, 2026, at 11:13 a.m., the surveyor again requested emergency testing documentation and LALD/RN-B stated the staff's training documentation was their only documentation and did not have anything further to provide. The licensee's Emergency Preparedness in Assisted Living Emergency Plan dated 2022, indicated two (2) exercises would be conducted at least annually to test the emergency plan, including unannounced staff drills using emergency procedures. The facility would analyze its response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan as needed. The licensee's Emergency Preparedness policy dated August 28, 2023, indicated that emergency exit diagrams would be posted on each floor of the facility. 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.	0 680			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37263	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER OPTIMUM HEALTHCARE SERVICES LL		STREET ADDRESS, CITY, STATE, ZIP CODE 5060 HUGHES AVENUE NE FRIDLEY, MN 55421			
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0 680	Continued From page 12	0 680			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37263	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2026
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0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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	0 780			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37263	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2026
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0 780	Continued From page 14 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, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 790			

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0 790	Continued From page 15 interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=E	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.	0 800			

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0 800	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
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	0 810			

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0 810	Continued From page 17 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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	0 810			

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0 810	Continued From page 18 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, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements	0 830			

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0 830	Continued From page 19 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910			

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0 910	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has not 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: During entrance conference on August 10, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B stated they did not currently have any residents, and their last resident discharged October 2025. On August 10, 2026, at 11:46 a.m., LALD/RN-B stated R1's assisted living contract was their current contract and no updates had been made. R1 was admitted for assisted living services on October 9, 2022, and discharged on October 18, 2025. R1's Assisted Living Contract signed October 4, 2022, lacked the licensee's health facility identification number (HFID) 37263. During exit conference on August 12, 2026, at 2:00 p.m., LALD/RN-B stated they thought the	0 910			

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0 910	Continued From page 21 license number listed on the contract was sufficient and was unaware it needed to be the HFID number. The licensee's Notifications policy dated August 28, 2023, indicated prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative, and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. 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 include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 970			

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0 970	Continued From page 22 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: During entrance conference on August 10, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B stated they did not currently have any residents, and their last resident discharged October 2025. R1 was admitted for assisted living services on October 9, 2022, and discharged on October 18, 2025. R1's Assisted Living Contract signed October 4, 2022, included the following section waving the licensee's liability for the health and safety or personal property of the resident: -Miscellaneous Provisions, "1. Insurance Liability and Release. The resident acknowledges [licensee name] will not be liable to the resident for any personal injury or property damagesuffered by the resident," and "The resident hereby releases [licensee name] from liability for any personal injury or property damage suffered by the resident ...unless caused by the negligence of [licensee name] or its employees or agents". During phone interview on August 12, 2026, at 11:13 p.m., LALD/RN-B stated they were not aware their contract included a waiver of liability. The licensee's Notifications policy dated August 28, 2023, indicated prior to providing housing or	0 970			

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0 970	Continued From page 23 assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative, and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for one of five employees (office assistant/unlicensed personnel (OA/ULP)-E).	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

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01290	Continued From page 24 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: During attempts to reach the licensee on August 10, 2026, at 8:41 a.m., the surveyor received a return call from OA/ULP-E and they explained they worked for licensee and that clinical nurse supervisor (CNS)-A and licensed assisted living director/registered nurse (LALD/RN)-B would be at the facility for the surveyor's arrival. During entrance conference on August 10, 2026, at 10:30 a.m., CNS-A and LALD/RN-B stated the licensee did not have any current residents and the last resident (R1) discharged from the facility on October 18, 2025. OA/ULP-E was hired under the licensee's comprehensive home care license in April 2021 and began providing assisted living services on August 1, 2021. On August 10, 2026, at 2:21 p.m., the surveyor received the NETStudy 2.0 Roster (web-based system used to submit BGS requests to the Department of Human Services (DHS)) from their supervisor. The roster did not include OA/ULP-E. OA/ULP-E's record lacked a cleared DHS background study affiliated with the licensee, completed upon start of assisted living licensure	01290			

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01290	Continued From page 25 on August 1, 2021. On August 10, 2026, at 3:20 p.m., CNS-A stated LALD/RN-B was responsible for completing BGS. CNS-A stated OA/ULP-E was a house manager when they had residents, but was currently working in the office. During phone interview on August 11, 2026, at 11:50 a.m., LALD/RN-B stated she was responsible for conducting BGS. During phone interview on August 12, 2026, at 8:50 a.m., LALD/RN-B stated any staff who were on their comprehensive home care roster were separated but they were not aware they needed to conduct another background study under their assisted living health facility identification number (HFID) 37262. The licensee's Recruitment and Hiring policy dated August 28, 2023, indicated the administrator or designee was responsible for initiating the criminal background study for new employees and NETStudy 2.0 would be used for the background check. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
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	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37263	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER OPTIMUM HEALTHCARE SERVICES LL			STREET ADDRESS, CITY, STATE, ZIP CODE 5060 HUGHES AVENUE NE FRIDLEY, MN 55421		
(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
01470	Continued From page 26 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 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	01470			

Minnesota Department of Health

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01470	Continued From page 27 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 interview and record review, the licensee failed to ensure orientation with all the required content was completed for two of three employees (unlicensed personnel (ULP)-C, office assistant/ULP (OA/ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 August 10, 2026, at 10:30 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-B stated employee orientation was completed on Educare (online training program), and annual training was completed on their anniversary hire date.	01470			

Minnesota Department of Health

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01470	Continued From page 28 Former employee ULP-C was hired on May 10, 2023, to provide assisted living services to residents. OA/ULP-E was hired in April 2021 (full date unknown), to provide assisted living services to residents. ULP-C and OA/ULP-E's employee records lacked documentation of a completed orientation to assisted living regulations with the required content related to: -overview of assisted living statutes; -handling of resident complaints, reporting of complaints, and where to report; -consumer advocacy services; and -review of types of assisted living services the employee will provide and provider's scope of license. During phone interview on August 12, 2026, at 11:13 a.m., LALD/RN-B stated they thought the missing orientation topics were covered under the assisted living bill of rights course on Educare. They were not aware there was missing orientation content. The licensee's Staff Orientation and Education policy dated August 28, 2023, indicated the following required orientation content would be provided to employees: -overview of Minnesota assisted living statutes; -grievance policy/process, including reports to the Office of Health Facility Complaints; -consumer advocacy services; and -types of assisted living services the employee would be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure.	01470			

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01470	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	01500			

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01500	Continued From page 30 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for three of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-C, office assistant/ULP (OA/ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	01500			

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01500	Continued From page 31 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: CNS-A CNS-A was hired in July 2021 (full date unknown), to provide clinical oversight. CNS-A's Educare transcript (online training program) lacked documentation of the following required annual training topics: -reporting maltreatment of vulnerable adults or minors (last completed April 2, 2025); -Assisted Living Bill of Rights (last completed April 15, 2023); -infection control techniques (last completed April 20, 2024); and -principles of person-centered planning/service delivery (last completed April 2, 2025). ULP-C Former employee ULP-C was hired on May 10, 2023, to provide assisted living services to residents and had a separation date of October 2025. ULP-C's Educare transcript lacked documentation of the following required annual training topics: -reporting maltreatment of vulnerable adults or minors (last completed February 4, 2024); and -Assisted Living Bill of Rights (last completed on February 5, 2024). OA/ULP-E OA/ULP-E was hired in April 2021 (full date unknown), to provide assisted living services to residents.	01500			

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01500	Continued From page 32 OA/ULP-E's Educare transcript lacked documentation of the following required annual training topics: -Assisted Living Bill of Rights (last completed on January 23, 2024). During phone interview on August 11, 2026, at 11:50ap.m., the surveyor asked licensed assisted living director/registered nurse (LALD/RN)-B if CNS-A completed any annual training for year 2026. LALD/RN-B stated she would forward any trainings CNS-A completed for 2026 on Educare and stated she sometimes had difficulty selecting the year when creating the Educare transcript. On August 11, 2026, at 9:02 p.m., via email, the licensee sent attached training records and indicated that CNS-A's Educare transcript provided was the most current transcript. LALD/RN-B also indicated CNS-A was currently in school completing her doctor of nursing practice in psychiatry and attached CNS-A's school transcript. The licensee's provided Staff Orientation and Education policy dated August 28, 2023, indicated that all staff that perform direct services would complete a minimum of eight hours of education for each 12 months of employment. Education topics would include, but not limited to, the following: -reporting of maltreatment of adults; -review of Assisted Living Bill of Rights and staff responsibilities; -review of licensee's policies and procedures; -infection control techniques; -effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with	01500			

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01500	Continued From page 33 residents who have dementia, Alzheimer's Disease, or related disorders; and -principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related	01530			

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01530	Continued From page 34 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 provide supervisors of direct-care staff at least two hours of training on topics related to dementia and failed to provide direct-care staff at least one (1) hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter for two of two employees (clinical nurse supervisor (CNS)-A, office assistant/unlicensed personnel (OA/ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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:	01530			

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01530	Continued From page 35 CNS-A CNS-A was hired in July 2021 (full date unknown), to provide clinical oversight. CNS-A's Educare transcript (online training program) lacked documentation of the following required annual training topic: -dementia (completed 2 hours of training on April 1, 2025). OA/ULP-E OA/ULP-E was hired in April 2021 (full date unknown), to provide assisted living services to residents. OA/ULP-E's Educare transcript lacked documentation of the following required annual training topic: -mental illness (completed 2.25 hours of training on July 5, 2025). During interview on August 12, 2026, at 11:13 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated two hours of mental illness training was required initially, then one hour of annually. LALD/RN-B stated she had not assigned mental illness courses on Educare. The licensee's Mental Illness & De-Escalation Training Clinical Records policy indicated the staff would complete at least two hours of initial mental illness and de-escalation training and at least one hour of mental illness and de-escalation training during each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

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03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect residents, staff, and any visitors to the facility. 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 August 10, 2026, at 12:50 p.m., during posting review with clinical nurse supervisor (CNS)-A, the surveyor did not observe a posted electronic monitoring notice with the required statutory language. The surveyor asked CNS-A where the required statutory language was posted, so they looked around the facility and were unable to locate it. CNS-A stated they would post it. CNS-A	03090			

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03090	Continued From page 37 later posted an 8 x 10 sheet of paper on the front door with the following information, "NOTICE ALL ACTIVITIES MONITORED BY VIDEO CAMERA." The surveyor explained to CNS-A that the posting did not include the required information and they stated they would include it. The licensee's Electronic Monitoring policy dated August 28, 2023, indicated the licensee would post a sign at each facility entrance accessible to visitors that stated "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Food & Beverage Inspection Report

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Establishment Info

OPTIMUM HEALTHCARE SERVICES LL
5060 Hughes Ave NE
Fridley, MN
Anoka County
Parcel:

Phone:

License Info

License: HFID 37263

Risk:
License:
Expires on:
CFPM: AYAN GELLE
CFPM #: 110724; Exp: 10-17-2027

Inspection Info

Report Number: F1062261174
Inspection Type: Full - Single
Date: 8/10/2026 Time: 11:45 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION CONDUCTED ON BEHALF OF ANNA BOHNEN HRD.

NO RESIDENTS HOUSED AT FACILITY AT TIME OF INSPECTION. SO NO FOODS WERE BEING HELD IN COLD HOLDING.

2 BASIN SINK WITH 1 BASIN DESIGNATED FOR HANDWASHING. TILE FLOORS, DRYWALL, LAMINATE COUNTERS.

DISCUSSED SUSCEPTIBLE POPULATIONS RULES, ILLNESS RECORDING, AND THERMOMETER USE FOR TRACKING HOLDING UNIT TEMPS.

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 F1062261174 from 8/10/2026

FARDOZA YUSUF
OPERATOR

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@state.mn.us



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
OPTIMUM HEALTHCARE SERVICES LL Fridley County/Group: Anoka County	Report Number: F1062261174 Inspection Type: Full Date: 8/10/2026 Time: 11:45 am

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37263016-0	Date: August 10, 2026
Facility Name: Optimum Healthcare Services LLC	
Facility Address: 5060 Hughes Avenue NE, Fridley, MN 55421	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Occupancy separation shall be provided in Group I and Group R occupancies. Existing wood lath and plaster in good condition or ½ inch gypsum wallboard is acceptable where one hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

Comments: In the attached garage, there were exposed wood lath surfaces and gaps between the wallboard and wood lath. The wall between the dwelling unit and attached garage was damaged under the electrical panel. The required one hour separation was not maintained.

3. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

Comments:

- The weatherproof cover was missing from one electrical wall outlet on the exterior of the building.
- Covers were missing from several electrical wall outlets and switches in the basement. Clinical nurse supervisor (CNS)-A stated these covers had been removed by the building owner. Additionally, one electrical switch cover was missing in the attached garage. Electrical outlet covers shall be installed to prevent accidental contact with live electrical components by the building occupants.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: When clinical nurse supervisor (CNS)-A tested the wireless battery operated smoke alarms in the building, none of the other dwelling unit smoke alarms were actuated. The dwelling unit smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments:

- The maintenance tags attached to the portable fire extinguishers installed in the dwelling unit were dated June 2024, indicating annual maintenance had not been performed by certified service personnel in the last year.
- There was a 1-A:10-B:C portable fire extinguisher stored on a countertop in the attached garage. This fire extinguisher did not meet the minimum rating requirement. Clinical nurse supervisor (CNS)-A stated this was an old extinguisher and would be removed.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern

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:

- The light was not working at the top of the basement stairs.
- The window blinds were damaged in unoccupied resident bedrooms, one and two on the main level.
- One section of closet trim was cracked in unoccupied resident bedroom one.
- The main level shared resident bathroom door was catching on the floor, making it difficult to operate.
- In the basement bathroom, the light was not working and there were several loose floor tiles.

- On the exterior of the building, one section of soffit was missing from the back of the building. Additionally, there were two exposed screws on the gate leading to the front yard.
- One deck floorboard was warped, creating a trip/fall hazard on the ramp installed at the front of the building. Additionally, one handrail at the base of the ramp was loose.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee provided an emergency binder with the fire safety and evacuation plans. Clinical nurse supervisor (CNS)-A stated this binder was sometimes stored in the locked medication closet.

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

Comments: During the building tour, the licensee verbally identified resident bedrooms by number. Number identifiers were not posted at the doors for bedrooms two, three, and four. Resident bedroom identifiers shall be posted, and the numbers installed at the bedroom doors need to correspond with the evacuation floor plans to provide efficient communication for exiting in the event of a fire or similar emergency. Additionally, the floor plan for the upper level labeled a room as storage and inappropriately included a bed symbol inside this room. The licensee stated this room was no longer used as a bedroom because the windows were too small to meet egress requirements.

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

Comments: The licensee failed to develop the fire safety and evacuation plans (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the assisted living building and environmental risks. The provided FSEP employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym and third party templates were used that inaccurately directed employees to use pull fire alarms. The FSEP emergency action plan inside the building in the event of a fire was limited to proceed to the nearest exit when the alarm sounds.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The provided fire safety and evacuation plans (FSEP) failed to include site specific fire safety and evacuation instructions for residents.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for employee training on the fire safety and evacuation plans (FSEP) completed in the last year from the licensee. Record review of the available documentation indicated employees completed FSEP training once in the past year, during February 2026. The surveyor requested FSEP training documentation for one new hire employee. This training documentation was not provided for review when requested. Employee training on the FSEP was not completed at the required frequency. Additionally, the training records did not include the names of the employees who participated.

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for resident fire safety and evacuation training completed in the last year from the licensee. Record review of the provided documentation indicated residents received this training on October 10, 2024, and no training was completed in 2025. Clinical nurse supervisor (CNS)-A stated no residents currently lived at this facility and the last resident was discharged on October 18, 2025. Residents were not offered this training at the required frequency of at least once per year.

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

Comments: The surveyor requested records for evacuation drills completed in the past year from the licensee. Record review of the provided fire drill logs indicated eight fire drills had been completed. The time or shift was not recorded on the 2026 drills conducted in April, June, and August. This information is needed to evaluate regulatory compliance. Additionally, the fire drill documentation lacked simulated fire locations and drill conditions.

☒ **TAG IDENTIFICATION: 0830**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Facility complies with all state and local governing laws, and codes for fire safety, building, and zoning requirements. [Minn. Stat. 144G.45 subd.3]

Comments: The surveyor requested a copy of the building permit for three egress windows replaced in resident bedrooms in 2025. This documentation was not provided when requested. Clinical nurse supervisor (CNS)-A stated they had reached out to the building contractor who installed the windows several times and requested this permit, but the contractor would not return their calls.