



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 7, 2026

Licensee

Mira Home Health Services LLC

7465 Harold Avenue North

Golden Valley, MN 55427

RE: Project Number(s) SL39889016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - 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/Bm5uQEpHV>**. 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,



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: 39889	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2026
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NAME OF PROVIDER OR SUPPLIER MIRA HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 HAROLD AVENUE NORTH GOLDEN VALLEY, MN 55427
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL39889016-0</p> <p>On March 9, 2026, through March 13, 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 two (2) residents receiving services under the Assisted Living Facility license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
0 340 SS=F	<p>144G.30 Subd. 5 Correction orders</p> <p>(a) A correction order may be issued whenever</p>	0 340		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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0 340	<p>Continued From page 1</p> <p>the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.</p> <p>(b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.</p> <p>(c) By the correction order date, the facility must:</p> <p>(1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed April 10, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to</p>	0 340		
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0 340	<p>Continued From page 2</p> <p>cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On May 9, 2024, the licensee received an enforcement letter, with the results from the previous survey concluded on April 10, 2024. The longest time period for correction (the time frame by which the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was June 7, 2024.</p> <p>The licensee's correction orders included tag identifiers: -0480 related to 1446.41 Subdivision 1. Subd. 1a. (a-b) Minimum requirements; required food services; -0660 related to 144G.42 Subd. 9. Tuberculosis prevention and control; -0790 related to 144G.45 Subd. 2{a} (2-3) Fire protection and physical environment; and -0810 related to 144G.45 Subd. 2 (b-f) Fire protection and physical environment.</p> <p>On March 9, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they believed the licensee had started to create a plan of correction but did not finish it. The surveyor did not receive a plan of correction document.</p> <p>During the survey initiated on March 9, 2026, and exited on March 13, 2026, areas of deficient practice related to tags 0480, 0660, 0790, and 0810 were identified and the correction orders were re-issued.</p>	0 340		
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0 340	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 460 SS=F	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;</p> <p>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;</p> <p>(7) permit residents access to food at any time;</p> <p>(8) allow residents to choose the resident's visitors and times of visits;</p> <p>(9) allow the resident the right to choose a roommate if sharing a unit;</p> <p>(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a</p>	0 460		

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0 460	<p>Continued From page 4</p> <p>resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On March 9, 2026, at approximately 10:20 a.m., during facility tour, the surveyor observed the facility was a multi-level home with a main floor, upper level, and lower level. The surveyor also observed no pendants, call light system, or means to request assistance were available in the residents' rooms.</p> <p>On March 9, 2026, at approximately 11:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated the licensee did not have a call light or pendant system the residents could use to summon staff as the current system they were using was not working. CNS-A also stated residents would verbally call out to the licensee's staff or leave their rooms and locate a staff member, if they needed assistance.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 460		
0 470 SS=F	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p>	0 470		

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0 470	<p>Continued From page 5</p> <p>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and</p> <p>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;</p> <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <p>(i) awake;</p> <p>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) reviewed the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect</p>	0 470		
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0 470	<p>Continued From page 6</p> <p>a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee held an assisted living license and was licensed for a capacity of five residents, with a current census of two residents.</p> <p>During a tour of the licensee's establishment on March 9, 2026, at 10:15 a.m., there was an undated staffing plan posted on a wall in the common area. The staffing plan had times of shifts posted on the form but there was no indication on the form that a staffing plan was developed. The form included the directions on how to develop a staffing plan. The form stated it was completed by clinical nurse supervisor (CNS)-A.</p> <p>During the entrance conference on March 9, 2026, at 11:14 a.m., CNS-A stated the licensee was familiar with current minimum assisted living requirements.</p> <p>On March 9, 2026, at 12:12 p.m., CNS-A stated they had developed a staffing plan but had not reviewed it at least twice per year. CNS-A stated he was not aware of this requirement but thought the staffing plan he had developed was correct.</p> <p>The licensee's Staffing policy dated August 1, 2021, indicated a staffing plan would be developed and evaluated at least twice per year by a CNS.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 470		

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0 480	Continued From page 7	0 480		
0 480 SS=F	<p>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:</p> <p>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;</p> <p>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;</p> <p>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;</p> <p>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;</p>	0 480		

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0 480	<p>Continued From page 8</p> <p>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;</p> <p>(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</p> <p>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 10 2026, for the specific Minnesota Food Code violations. The Inspection</p>	0 480		
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0 480	Continued From page 9 Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 570 SS=C	<p>144G.42 Subdivision 1 Display of license</p> <p>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee held an assisted living license effective April 24, 2025, with an expiration date of April 24, 2026.</p> <p>On March 9, 2026, at 10:40 a.m., during the facility tour with clinical nurse supervisor (CNS)-A, the surveyor observed the facility's main entrance with a hallway leading to the common living area.</p>	0 570		

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0 570	<p>Continued From page 10</p> <p>The surveyor also observed the licensee had posted a current assisted living facility license in the facility's community living room area bulletin board next to the door of the licensee's employee office. The common living area was located past the hallway of the main entrance.</p> <p>On March 9, 2026, at 10:45 a.m., CNS-A acknowledged the location of the licensee's posted license and stated they thought the licensee's assisted living license was displayed in the correct area. CNS-A also stated they were unaware that the license should be posted by the main entrance.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 570		
0 640 SS=F	<p>144G.42 Subd. 7 Posting information for reporting suspected c</p> <p>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:</p> <ol style="list-style-type: none"> (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. <p>This MN Requirement is not met as evidenced by:</p>	0 640		

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0 640	<p>Continued From page 11</p> <p>Based on observation, interview, and record review, the licensee failed to post required content to include the 911 emergency number in common areas. This had the potential to affect all residents, staff, and visitors. .</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On March 9, 2026, at approximately 10:40 a.m., during a facility tour, the surveyor observed the common areas shared by residents, staff, and visitors, lacked a posting of information to include the 911 emergency number.</p> <p>On March 9, 2026, at approximately 10:45 a.m., clinical nurse supervisor (CNS)-A acknowledged the required content was not posted in the common areas. CNS-A stated it was an oversight, and the licensee would post the information to include the 911 emergency number.</p> <p>The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy was requested but not received.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 640		
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0 650 SS=D	<p>144G.42 Subd. 8 (a) Staff records</p> <p>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of one employees (unlicensed personnel (ULP)-B).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a</p>	0 650		
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0 650	<p>Continued From page 13</p> <p>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>ULP-B was hired by the licensee on July 18, 2025.</p> <p>ULP-B's personnel record lacked evidence an RN conducted direct supervision of staff performing a delegated task within 30 days of providing services.</p> <p>On March 9, 2026, at 11:26 a.m., clinical nurse supervisor (CNS)-A stated they usually would do their supervision of ULPs monthly and stated he would not document these supervision visits.</p> <p>The licensee's Supervision of Staff policy was requested but not received.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 650		
0 660 SS=F	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(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</p>	0 660		

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0 660	<p>Continued From page 14</p> <p>covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a facility TB risk assessment and completion of TB screening for active symptoms of TB for one of one employees (unlicensed personnel (ULP)-B).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on March 9, 2026, at 11:00 a.m. with clinical nurse supervisor (CNS)-A, a request was made to review the facility TB risk assessment. CNS-A stated the licensee had completed a facility TB risk assessment but was unsure where to locate it. CNS-A stated the licensee would attempt to find the assessment and provide to surveyor.</p>	0 660		
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0 660	<p>Continued From page 15</p> <p>ULP-B was hired on July 18, 2025, to provide direct care to the licensee's residents.</p> <p>ULP-B's Tuberculosis Screening Result dated September 2, 2025, indicated ULP-B was negative for TB based on a QuantiFERON blood test.</p> <p>ULP-B's employee record lacked completion of a Baseline TB Screening Tool for Health Care Workers (HCWs) assessing symptoms of active TB disease.</p> <p>During interview on March 9, 2026, at 12:00 p.m., house manager (HM)-C stated the licensee was not aware ULP-B's employee record lacked the documentation of a completed TB screening form.</p> <p>At the time of exit on March 13, 2026, at 3:00 p.m., the licensee had not provided a TB risk assessment to surveyor.</p> <p>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 a TB infection control program should include a facility TB risk assessment.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	<p>Continued From page 16</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to review the missing person policy at least quarterly as per Minnesota Rules Chapter 4659.0110 Subpart 4. This had the potential to affect all residents, staff, and visitors of the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and</p>	0 680		
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0 680	<p>Continued From page 17</p> <p>is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's Missing Resident policy dated August 1, 2021, lacked evidence the licensed assisted living director (LALD) and clinical nurse supervisor (CNS) reviewed or updated the policy and documented any changes, at least quarterly as required.</p> <p>On March 9, 2026, at 1:00 p.m., CNS-A stated the missing resident policy had not been reviewed or updated quarterly as required. CNS-A indicated he was not aware the licensee was required to review the missing resident policy quarterly.</p> <p>The licensee's Missing Resident policy dated August 1, 2021, did not indicate the licensee would review the policy at least quarterly.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subpart 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 700 SS=F	<p>144G.43 Subdivision 1 Resident record</p> <p>(b) Resident records, whether written or</p>	0 700		

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0 700	<p>Continued From page 18</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect all residents residing within the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On March 9, 2026, at 10:50 a.m. during the facility tour with clinical nurse supervisor (CNS)-A, the surveyor was shown an unlocked room that contained a desk, file cabinets, and miscellaneous office supplies. CNS-A stated the room was available for staff. CNS-A also stated the staff used this room for shift-to-shift report, documenting in resident records, and for storing resident records and resident medications. CNS-A stated the door to the room had a lock that was non-functioning and needed to be</p>	0 700		
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0 700	<p>Continued From page 19</p> <p>repaired. Another lock that was on the door was a sliding latch that anyone could open. This latch was placed on the outside of the door.</p> <p>On March 9, 2026, at 11:01 a.m., the surveyor noted a file cabinet in the room that CNS-A stated the paper resident records were kept. The surveyor noted four resident record binders in the unlocked cabinet. CNS-A stated the four binders included private medical information for residents and was accessible to anyone who had access to the room. CNS-A advised the surveyor the file cabinet had a broken lock and needed to be repaired.</p> <p>The licensee's Resident Confidentiality policy dated August 1, 2021, indicated resident records would be kept confidential.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 700		
0 775 SS=F	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.</p>	0 775		

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0 775	<p>Continued From page 20</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/11/2026, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 775		
0 790 SS=F	<p>144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment</p> <p>(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</p> <p>This MN Requirement is not met as evidenced by:</p>	0 790		

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0 790	<p>Continued From page 21</p> <p>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/11/2026, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 790		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <p>(1) location and number of resident sleeping rooms;</p> <p>(2) staff actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p>	0 810		

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0 810	<p>Continued From page 22</p> <p>(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.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic</p>	0 810		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39889	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2026
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NAME OF PROVIDER OR SUPPLIER MIRA HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 HAROLD AVENUE NORTH GOLDEN VALLEY, MN 55427
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	<p>Continued From page 23</p> <p>failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/11/2026, for the specific violations related the physical environment under Minnesota Statute 144G.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 810		
01530 SS=E	<p>144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-</p> <p>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:</p> <p>(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;</p> <p>(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</p>	01530		

Minnesota Department of Health

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01530	<p>Continued From page 24</p> <p>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;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees completed dementia care training for two of two employees (clinical nurse supervisor (CNS)-A) and (unlicensed personnel (ULP)-B)) and two hours of initial training on mental illness and de-escalation topics for one of two employees (CNS-A).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p>	01530		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER MIRA HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 HAROLD AVENUE NORTH GOLDEN VALLEY, MN 55427
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01530	<p>Continued From page 25</p> <p>The findings include:</p> <p>CNS-A CNS-A was hired on August 27, 2023, and provided direct nursing care and services to residents, and supervision of staff.</p> <p>CNS-A's employee record lacked documentation they completed at least eight hours within 120 working hours of the employment start date and the required two hours of initial training on mental illness and de-escalation topics, effective July 1, 2025.</p> <p>ULP-B ULP-B was hired on July 18, 2025, and provided direct care and services to residents.</p> <p>ULP-B's education transcript, dated March 9, 2026, indicated that they had completed 2 hours of dementia education training.</p> <p>ULP-B's employee record lacked documentation they completed at least eight hours within 160 working hours of the employment start date.</p> <p>On March 9, 2026, at 1:50 p.m., CNS-A confirmed their employee record lacked documentation indicating that they had completed two hours of training on mental illness and de-escalation topics and lacked eight hours of dementia training. CNS-A stated he believed he had completed the training and would need to obtain his education record and would provide to the surveyor as soon as it was found.</p> <p>On March 9, 2026, at 1:55 p.m., ULP-B stated he was in the process of completing his required education and acknowledged he had not completed at least eight hours within 160 working</p>	01530		
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Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER MIRA HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 HAROLD AVENUE NORTH GOLDEN VALLEY, MN 55427
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01530	<p>Continued From page 26</p> <p>hours of the employment start date.</p> <p>The licensee's Dementia Education policy dated August 1, 2021, indicated all employees would complete at least eight hours within 160 working hours of employment start date. The policy lacked documentation regarding the required two hours of initial training on mental illness and de-escalation topics.</p> <p>At the time of survey exit on March 13, 2026, CNS-A had not provided any documentation of completing the required education.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01530		
01820 SS=D	<p>144G.71 Subd. 13 Prescriptions</p> <p>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for one of one resident (R1).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to</p>	01820		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER MIRA HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 HAROLD AVENUE NORTH GOLDEN VALLEY, MN 55427
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01820	<p>Continued From page 27</p> <p>cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 was admitted to licensee on February 20, 2026, with a diagnosis of post-traumatic stress disorder.</p> <p>R1's Service Plan Agreement dated February 20, 2026, indicated R1 received services including medication management, meal assistance, housekeeping, and laundry.</p> <p>R1's undated provider orders document indicated the following medications were to be administered to R1: -sertraline (to treat depression) 100 milligram (mg) tablet; take one tablet by mouth in the morning; -acetaminophen (to treat pain) 250 mg capsule; take two capsules by mouth as needed every eight hours; -hydroxyzine (to treat anxiety) 25 mg tablet; take one to two tablets by mouth twice daily as needed.</p> <p>R1's resident record lacked signed prescriber's orders for medications administered by the licensee.</p> <p>On March 9, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A verified R1's record lacked signed prescriber's orders for the above listed medications. CNS-A stated that he had faxed R1's physician and was still waiting for a response. CNS-A stated he could not remember</p>	01820		
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Minnesota Department of Health

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01820	<p>Continued From page 28</p> <p>when he had faxed the request to the prescriber and stated he did not follow up with the provider when he had not received a response.</p> <p>The licensee's Prescriber's Orders policy dated August 1, 2021, indicated written orders from an authorized prescriber would be obtained for medications with which the assisted living licensee assists residents with, including over the counter medications.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01820		



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Mira Home Health Services LLC
7465 Harold Ave No
Golden Valley, MN 55427
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39889

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

Inspection Info

Report Number: F1047261075
Inspection Type: Full - Single
Date: 3/10/2026 Time: 10:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3 CFP#: 2*

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: REPEAT ORDER- FIRST ISSUED 4/8/24.

NO STATE CERTIFIED FOOD PROTECTION MANAGER FOR THE ESTABLISHMENT. INFORMATION ON GETTING THE STATE CERTIFICATION WAS SENT WITH THE REPORT.

Comply By: 4/10/2026 Originally Issued On: 3/10/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: UNABLE TO LOCATE PROBE THERMOMETER AT TIME OF INSPECTION

Comply By: 3/10/2026 Originally Issued On: 3/10/2026

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT: FACILITY DOES NOT HAVE A THERMOMETER OR ALTERNATE METHOD TO MEASURE THE DISHWASHER TEMP. DISCUSSED NEED TO GET A WATERPROOF THERMOMETER THAT MEETS THE ABOVE REQUIREMENTS

Comply By: 3/10/2026 Originally Issued On: 3/10/2026

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator E. Jones.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, tile floor, painted and textured walls, granite counter top, and a painted ceiling.

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

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 F1047261075 from 3/10/2026



Luul Daywali
Operator

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Mira Home Health Services LLC
Golden Valley
County/Group: Hennepin County

Inspection Info

Report Number: F1047261075
Inspection Type: Full
Date: 3/10/2026
Time: 10:00 am

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

Location: Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Mira Home Health Services LLC
Golden Valley
County/Group: Hennepin County

Inspection Info

Report Number: F1047261075
Inspection Type: Full
Date: 3/10/2026
Time: 10:00 am

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Greater Than 170 Degrees F.**

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39889016-0	Date: 3/11/2026
Facility Name: MIRA HOME HEALTH SERVICES LLC	
Facility Address: 7465 Harold Ave No Golden Valley, MN 55427	

TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

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: An opening in the garage ceiling for rafter access was observed without a protective cover, resulting in an unprotected penetration of the ceiling membrane at the time of the survey.

3. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: The basement egress door and the upstairs egress door leading to the deck were observed to be obstructed by accumulated snow, preventing safe and unobstructed egress at the time of the survey.

4. Electrical wiring, devices, appliances and other equipment that is modified or damaged and constitutes an electrical shock or fire hazard shall not be used. [Minn. Stat. 144G.45 subd. 2; MSFC 604.1]

Comments: Inside Resident Room 1, a non-UL listed extension cord was observed in use that appeared to have an electrical short, evidenced by visible burn marks. The extension cord was located on top of a pile of blankets, creating a potential fire hazard.

TAG IDENTIFICATION: 0790

SCOPE/ SEVERITY: Level 2; Widespread

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: A portable fire extinguisher located in the garage was observed to have a last documented annual service tag from 2024, indicating the annual maintenance was not current. Additionally, fire extinguishers throughout the building were observed to be mounted with the top of the units exceeding the maximum allowable height of 60 inches.

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 FSEP was not readily available for staff and residents to access. FSEP was in a locked room inside the facility's office area.

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

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.

3. 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 FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

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

Comments: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan

included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation.