Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 10, 2026

Licensee
3MB Health Services LLC
10301 Humboldt Avenue South
Bloomington, MN 55431

RE: License Number 418678
Health Facility Identification Number (HFID) 41365
Project Number(s) SL41365015

Dear Licensee:

On January 17, 2026, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed September 3, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 17, 2026.

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

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

KKM

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

October 21, 2025

Licensee
3mb health services LLC
10301 Humboldt Avenue South
Bloomington, MN 55431

RE: Provisional Conditional License Number 418678
Health Facility Identification Number (HFID) 41365
Project Number(s) SL41365015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 3, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **January 19, 2026**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $1,500.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:
MDH will issue 3mb health services LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar

days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if 3mb health services LLC is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** 3mb health services LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. 3mb health services LLC must provide the Department:

   i. A list of the names and birthdates of any individuals 3mb health services LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current residents including:
      1. Name and birthdate of each resident
      2. Current payment source for services
      3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
      4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of 3mb health services LLC to correct the violations cited during the survey as well as to determine the overall practice of 3mb health services LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

e. **Corrective Action Plan:** 3mb health services LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that

includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if 3mb health services LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines 3mb health services LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to 3mb health services LLC. If MDH determines 3mb health services LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Renee L. Anderson directly at: 651-201-5871.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41365	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3MB HEALTH SERVICES LLC	10301 HUMBOLDT AVENUE SOUTH BLOOMINGTON, MN 55431

(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: SL41365015-0 On September 2, 2025, through September 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the Provisional Assisted Living Facility license. An immediate correction order was issued September 2, 2025, for SL41365015-0 correction tag 0470. The licensee submitted a plan of correction to mitigate the immediate risk. Scope and severity remain the same.	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.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (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 (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; (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: (i) awake; (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; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing 24 hours per day, seven days per week, to meet the scheduled and reasonably foreseeable unscheduled needs of each resident and to ensure the facility could respond promptly and effectively in the event of an emergency.	0 470	The licensee submitted a plan of correction to mitigate the immediate risk. Scope and severity remain the same.	

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0 470	Continued From page 2 This practice resulted in a level three violation (a violation that harmed a client's/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 clients/residents). The findings include: R1's Service Agreement - Service Plan, dated February 17, 2025, indicated R1 received services including assistance with housekeeping, laundry, meals, dressing, grooming, bathing, hands-on assistance with transfers and mobility, and medication administration. R1's medical record included a Master Care Plan dated, June 26, 2025. The care plan indicated, "Safety - Emergency Response: Needs help in emergency - is not able to evacuate without help, specify: - Note: Resident needs full assistance due to limited abilities. Resident will require two people assist with Hoyer to w/c {wheelchair} during emergency." R1's nursing assessment dated June 26, 2026, indicated, "Emergency Response: Needs help in emergency - is not able to evacuate without help, specify: Resident needs full assistance due to limited abilities. Resident will require two people assist with Hoyer to w/c during emergency." In addition, the assessment indicated, "Evacuation Activity Level: Level 4 - Resident who is non-ambulatory and requires continuous nursing care and observation and full assistance in evacuation."	0 470		

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0 470	Continued From page 3 On September 2, 2025, at 8:34 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated via phone that she was not at the facility, but could get there by 10:30 a.m., to meet the surveyor to initiate the provisional survey. On September 2, 2025, at 10:35 a.m., during the entrance conference, LALD/CNS-A stated on Mondays and Tuesdays, the licensee scheduled two caregivers for the day shift (7:00 a.m., to 3:00 p.m.), two caregivers for evening shift (3:00 p.m., to 11:00 p.m.), and one caregiver on the night shift (11:00 p.m., to 7:00 a.m.). LALD/CNS-A stated Wednesday through Sunday the licensee staffed 12 hour shifts with one caregiver from 7:00 a.m., to 7:00 p.m., and one caregiver 7:00 p.m., to 7:00 a.m. LALD/CNS-A stated she would come to the facility if needed and at differing times Monday through Friday each week. On September 2, 2025, at 12:34 p.m., unlicensed personnel (ULP)-B stated she was the only caregiver at the facility that morning until LALD/CNS-A arrived around 10:30 a.m. ULP-B stated LALD/CNS-A would come to the facility at some time most day shifts during the week to help as needed. ULP-B stated there was one staff member scheduled each shift. On September 2, 2025, at 1:08 p.m., the surveyor observed ULP-B and ULP-C assist R1 to transfer from wheelchair to bed using a mechanical lift. On September 2, 2025, at 1:57 p.m., LALD/CNS-A stated she lived 15 minutes from the facility and R1's daughter lived in another	0 470		

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0 470	Continued From page 4 city, which was approximately 25 minutes away from the facility. The licensee's timesheets dated August 20, 2025, through August 23, 2025, indicated the following hours were documented as worked: August 20 - one ULP 7:00 a.m., to 7:00 p.m., and one ULP 11:00 p.m., to 7:00 a.m.; August 21 - one ULP 7:00 a.m., to 7:00 p.m., and one ULP 7:00 p.m., to 7:00 a.m.; August 22 - one ULP 7:00 a.m., to 7:00 p.m., and one ULP 7:00 p.m., to 8:35 a.m.; and August 23 - one ULP 7:00 p.m., to 7:00 a.m., and one ULP from 7:00 a.m., to 7:00 p.m. The licensee's direct care staffing plan, dated August 23, 2025, indicated, there was to be scheduled two caregivers on day shift and evening shift, then one caregiver on night shift. In addition, the direct care staffing plan indicated, "Goals and Objectives: to provide an adequate number of qualified direct-care staff to meet our resident's needs 24 hours a day, seven days a week. To ensure each staffing resident's levels are needs as adequate identified to in address: the resident's service plan and assisted living contract. -Each resident's acuity level as determined by the most recent assessments. -Staff will meet the resident's scheduled and reasonably foreseen unscheduled needs given the physical layout of the facility in a timely manner. -Ability to respond promptly to individual resident emergencies and disaster situations." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		

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0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts	0 480		

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0 480	Continued From page 6 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; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 2, 2025, for the specific Minnesota Food Code violations. The	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 480	Continued From page 7 Inspection 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		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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	0 580		

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0 580	Continued From page 8 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, at 11:10 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had not yet completed or documented a quality management meeting. On September 3, 2025, at 10:00 a.m., LALD/CNS-A stated she had not created a quality management program or documented a quality management meeting for the program. LALD/CNS-A verbalized she planned to get a quality management program and meeting documented. The licensee's Quality Management Plan policy reviewed July 22, 2023, indicated, "PROCEDURE: 1. The Home Care Director will establish a quality management program to develop and maintain the agency's continuous performance improvement efforts. 2. The Home Care Director will establish a Quality team made up of key staff to develop and implement the agency's quality management program. 3. The Quality team meetings will be held at least quarterly to identify and review quality measures, set goals and identify needed changes in procedures or training for staff." In addition, included, "Retention of documents of the Quality Management Team will be retained in the agency files for two years and will be made available to the Minnesota Department of Health upon request. Documents to be retained include	0 580		

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3MB HEALTH SERVICES LLC	10301 HUMBOLDT AVENUE SOUTH BLOOMINGTON, MN 55431

(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
0 580	Continued From page 9 a summary of meeting minutes, quality metric trends and other relevant information." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 10 Based on interview and record review, the licensee failed to have all the written requirements in the emergency preparedness plan (EPP) as defined in Appendix Z (a section of the Centers for Medicare and Medicaid Services (CMS) state operations manual which includes the emergency preparedness guidelines). In addition, the licensee failed to ensure the missing resident policy was reviewed quarterly as required under section 4659.0110. This had the potential to affect all residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 3, 2025, at 10:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided the licensee's EPP binder. The EPP binder contained emergency preparedness planning templates which had not yet been filled out by the licensee. The licensee's undated emergency disaster preparedness plan lacked evidence of annual review and the following required content: -EP plan reviewed and updated annually; -a description of the population served by the licensee; -quarterly review of missing resident policy;	0 680		

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0 680	Continued From page 11 -communication plan containing all required elements; -hazard vulnerability assessment; -process for emergency plan collaboration; -subsistence needs for staff and residents; -procedures for tracking evacuated residents and staff; -policies for sheltering in place; -policies and procedures for medical documents; -policies and procedures for volunteers; -roles under a wavier declared by secretary; -emergency officials contact information; -methods for sharing information; -sharing information on occupancy and needs; -long term care family notifications; and -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise. On September 3, 2025, at 10:10 a.m., LALD/CNS-A verbalized she recently purchased the emergency preparedness program manual from Care Providers but has not yet completed or documented the facility specific emergency planning for the facility. LALD/CNS-A stated she was familiar with Appendix Z, but the licensee had not fully developed and implemented the facility's emergency preparedness plan/program to include the above requirements. Additionally, LALD/CNS-A verbalized she was not aware of the requirement to participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise. The licensee's undated Emergency Management	0 680		

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0 680	Continued From page 12 Policy, indicated, "Facility will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. The plan considers the facility's commitment to provide service while ensuring the safety of its employees and residents. The facility will implement this Emergency Management Policy as soon as the facility becomes aware of the existence of an emergency. An emergency is a natural or human made event that significantly disrupts the environment of care. For example, damage to the facility's buildings, such as severe winds, storms or earthquakes that disrupt care and treatment, loss of utilities due to floods, civil disturbances, accidents or emergencies in the facility or its community or that result in sudden significantly changed or increased demands for the facility's services (bio-terrorist attack, plane crash in local community etc.). The facility conducts an analysis to identify potential emergencies and the direct and indirect effects these emergencies may have on facility operations and the demand for services. The facility will develop and maintain a written emergency management plan describing the process for disaster readiness and emergency management and implements it as appropriate." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 13 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 14 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff documented all services were provided, or why services were not provided as identified in the service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 17, 2025. R1's service plan, dated February 17, 2025, indicated R1 received services including assistance with meals, and feeding. On September 2, 2025, at 1:08 p.m., R1's daughter stated R1 was not eating much, and she was concerned about possible weight loss. R1's daughter verbalized neither the licensee, nor R1's medical clinic had been unable to weigh R1 due to R1 needing a wheelchair scale. R1's	0 730		

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0 730	Continued From page 15 daughter stated the staff tried to offer him food but there were times he would refuse. Finally, R1's daughter verbalized at his last provider appointment, they were referred to a dietitian. On September 3, 2025, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-B assisting R1 with eating breakfast in his bed. ULP-B stated R1 was unable to feed himself and required assistance with all meals. ULP-B also stated sometimes R1 refused to eat meals. R1's Service Recap Summary dated August 1, 2025 to September 2, 2025, lacked any documentation of staff assisting R1 with meals, or any documentation of meals refused. R1's nursing assessment dated June 26, 2025, indicated, "activities of daily living (ADL) needs, Eating Needs - Feeding. Needs full assistance with eating and/or drinking, specify: Resident requires full assistance with setting up food and feeding due to limited ability to use the right hand. Needs assistance with in between meals snacks /nutritional supplements due to swallowing difficulties. Needs to be supervised while eating and/or drinking due to difficulty swallowing, specify: Resident has hx of dysphagia. He requires full assistance with eating/ drinking to monitor resident eating. Needs to be supervised while eating and drinking due to eating disorder, specify: Due to hx of dysphagia and risk for aspiration, staff will monitor and assist resident during mealtimes, in-between meals and drinking." On September 3, 2025, at 9:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and ULP-B stated staff provided	0 730		

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0 730	Continued From page 16 feeding assistance to R1 with his meals due to R1's medical needs. LALD/CNS-A stated they did not document the feedings provided to R1 in the licensee's electronic medical record, but she planned to get this service added to R1's electronic medical record so this service can be documented. The licensee's undated Service Plan policy, indicated, "Assisted living services will be provided according to a suitable and current written service plan. The service plan is developed with the resident/representative and is based on resident needs and preferences." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=F	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 and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 775		

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0 775	Continued From page 17 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 September 2, 2025, from 12:30 p.m. to 3:00 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the tour, the surveyor observed: POWER SOURCE: Battery powered smoke alarms in the common area of the basement and in resident rooms 4 and 5, was not the correct power source. When alarm was removed, to check manufacture date, wires for a hard-wired alarm was present in the ceiling. Hard-wired alarms shall be maintained in the facility and must be interconnected throughout. EXTENSION CORDS: In the laundry room, an extension cord was being used to provide continuous power to the washing machine. Electrical extension cords are intended for temporary use and not a permanent source of power. During a facility tour on September 2, 2025, at 2:30 p.m., LALD/CNS-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 18 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 19 review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, from 12:30 p.m. to 3:00 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A., While on tour, surveyor noticed facility floor plans did not match room numbers on resident bedroom doors. During the survey, LALD/CNS-A had staff make the correction and new corrected maps were printed and hung on the walls. September 2, 2025, at 2:30 p.m., LALD/CNS-A provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Emergency Plan", dated May 29, 2023, failed to include the following: STAFF ACTIONS: The FSEP included standard employee	0 810		

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0 810	Continued From page 20 procedures but 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 plan included 3 fire situations scenarios that provided steps to follow in those specific circumstances. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility. RESIDENT ACTIONS: 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. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility is getting set-up with an electronic care plan website which will include standard resident evacuation needs. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. There was no documentation on unique and unusual resident need for the current resident. On September 2, 2025, at 2:30 p.m., LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A lacked documentation showing any training was	0 810		

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0 810	Continued From page 21 offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/CNS-A provided a sheet showing training dates but was not able to provide any supporting documentation to show that staff were trained on their FSEP. No other training documentation was provided. On September 2, 2025, at 2:30 p.m., LALD/CNS-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD/CNS-A stated they had conducted 2 fire drills since obtaining their license but was unable to provide any supporting documentation. On September 2, 2025, at 2:30 p.m., LALD/CNS-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.	01620		

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01620	Continued From page 22 (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.	01620		

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01620	Continued From page 23 (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after start of services for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, at 10:35 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R1 was admitted on February 17, 2025.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41365	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 24 R1's Service Agreement - Service Plan, dated February 17, 2025, indicated R1 received services including assistance with housekeeping, laundry, meals, grooming, toileting, bathing, feeding, transfers, and medication administration. On September 2, 2025, at 1:08 p.m., the surveyor observed unlicensed personnel (ULP)-B and ULP-C assist R1 to transfer from wheelchair to bed using a mechanical lift. R1's medical record included an initial Assessment, dated February 17, 2025, and a subsequent nursing assessment dated March 19, 2025, greater than 14 days after start of services. On September 3, 2025, at 8:48 a.m., LALD/CNS-A stated, she thought she completed R1's 14-day assessment before the licensee transitioned to the current electronic medical record. LALD/CNS-A verbalized she did not find R1's 14-day assessment in R1's medical record. The licensee's undated Comprehensive Resident Assessment policy, indicated, "Resident assessment and monitoring must be conducted no more than 14 days after initiation of services. On-going resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. All assessments will be included in the resident record." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in a substantially constructed compartment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 17, 2025. R1's Service Agreement - Service Plan, dated February 17, 2025, indicated R1 received services including assistance with housekeeping, laundry, meals, grooming, toileting, bathing, feeding, transfers, and medication administration. On September 2, 2025, at 11:18 a.m., during a facility tour with unlicensed personnel (ULP)-B, ULP-B stated the licensee stored medications in an unlocked closet in the hallway on the main	01880		

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01880	Continued From page 26 floor of the facility. On September 3, 2025, at 8:02 a.m., the surveyor observed ULP-B assist R1 with medication administration. ULP-B removed R1's medications from the unlocked medication closet and proceeded to assist R1 with morning medication administration. On September 2, 2025, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all R1's medications were stored currently in the unlocked hallway closet, and she was not aware the residents' medications were required to be locked and secured. R1's assessment dated June 26, 2025, indicated R1 required full assistance with medication administration and was unable to self-administer medications, and all medications were stored in a locked cabinet in the resident's room. R1's medication administration record (MAR) for September 2025, indicated R1 was scheduled the following medications: -acetaminophen (for pain) 500 milligrams (mg), two tablets, twice daily; -aspirin (for pain) 81 mg extended release, one tablet, once daily; -daily-vite (a multivitamin supplement), one tablet, once daily; -ketotifen (for itchy eyes) 0.025 percent (%), one drop in both eyes, twice daily; -mineral oil and petrolatum (a protective skin barrier) white cream, apply to buttocks, three times daily; -neomycin/polymyxin B/dexamethasone (to prevent eye infections) eye ointment, apply 1/4	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 27 inch in left eye, three times daily; -polyethylene glycol powder (for constipation) 3350 NF, mix 17 grams (gm), in liquid, once daily; -zinc oxide (a protective skin barrier) 7%, apply to buttocks, twice daily; -atorvastatin (to lower cholesterol) 40 mg, one tablet, once daily at bedtime; -latanoprost (for glaucoma) 0.005%, one drop in right eye, once daily at bedtime; -levetiracetam (to treat seizures) 750 mg, one tablet, twice daily; -melatonin (for sleep) 5 mg, one tablet, once daily at bedtime; -mirtazapine (for depression) 15 mg, one tablet, once daily at bedtime; and -Nystatin (an antifungal) 100000 units/gm cream, to affected areas, twice daily. On September 3, 2025, at 8:20 a.m., LALD/CNS-A verbalized she planned to follow up and ensure a lock gets placed on the closet where the resident medications were being stored. The licensee's undated Medication Management Services policy, indicated, "SPECIAL INSTRUCTIONS: 1. Determination of Scope of Medication Management Services. The Assisted Living Director and Nursing Supervisor will determine the scope of medication management services the facility will offer, which may include: a. Medication set-ups b. Administration of medications c. Storing and securing medications d. Documenting medication activities e. Verifying and monitoring effectiveness of systems to ensure safe handling and administration	01880		

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01880	Continued From page 28 f. Coordinating refills g. Handling and implementing changes to prescriptions h. Communicating with the pharmacy about the resident's medications i. Coordinating and communicating with the prescriber; and j. Communicating with the resident, their representative and, when appropriate, the resident's family." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 and interview, the licensee failed to ensure the required posting at the main entry way of the facility, included statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on	03090		

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03090	Continued From page 29 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 the potential to affect a large portion or all the residents). The findings include: On September 2, 2025, at 11:12 a.m., the surveyor observed the licensee's postings within the presence of unlicensed personnel (ULP)-B. The licensee lacked an electronic monitoring notice posted with the required statutory language. On September 2, 2025, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware the electronic monitoring posting verbiage was required if the licensee was not currently using electronic monitoring. -at 11:35 a.m., the surveyor provided, via email, the statutory language for the electronic monitoring posting notification to the licensee. 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

Establishment Info

3MB Health Services LLC
1702 13th Avenue W
Shakopee, MN 55379
Scott County
Parcel:

Phone:

License Info

License: 0042376

Risk:
License: -1
Expires on: 12/31/2024
CFPM: Barbara Onwona Appiah
CFPM #: 8939; Exp: 6/25/2027

Inspection Info

Report Number: F1018251061
Inspection Type: Full - Single
Date: 9/2/2025 Time: 8:38:55 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: Establishment does not currently have an illness log for recording instance of illness in food employees. Illness log sent with report.
Comply By: 9/2/2025 Originally Issued On: 9/2/2025

Food & Beverage General Comment

Establishment is a residential home with residential equipment.

All food is prepared for same day service.

Establishment has a dishwasher with sanitize function available. Test strip indicated that appropriate temperature was achieved during cycle.

Kitchen has a two-basin sink with one basin for hand washing and one basin for food prep.

Floors, walls, and ceilings were observed to be in good condition at the time of inspection.

Equipment and physical facilities were observed to be in good condition.

Establishment has a needle point thermometer for measuring food temperatures.

Discussed pest control, and employee illness policy.

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 F1018251061 from 9/2/2025

Rebecca Prestemon

Barbara Onwona Appiah
Manager

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

3MB Health Services LLC
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F1018251061
Inspection Type: Full
Date: 9/2/2025
Time: 8:38:55 AM

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

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

Sanitizer Observations/Recordings

Establishment Info

3MB Health Services LLC
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F1018251061
Inspection Type: Full
Date: 9/2/2025
Time: 8:38:55 AM

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