Electronically Delivered

April 2, 2026

Licensee
Residential Care Nine Mile Creek
7421 13th Avenue South
Richfield, MN 55423

RE: Project Number SL37272016

Dear Licensee:

On September 2, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 12, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 8, 2025

Licensee
Residential Care at Nine Mile Creek
7421 13th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL37272016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37272	A. BUILDING: _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ****ATTENTION**** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37272016-0 On June 9, 2025, through June 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following orders are issued. At the time of the survey, there were four residents, all receiving services under the Assisted Living Facility license. An immediate correction order was issued June 10, 2025, for SL37272016-0 correction tag 0775.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 485 SS=F	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a menu was prepared at least a week in advance and made available to the residents. This had the potential to affect the four (4) residents who were residing in 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	0 485		

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0 485	Continued From page 4 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 9, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided three meals daily and snacks were provided and offered per the Minnesota food code. On June 9, 2025, at 12:10 p.m., when asked when lunch was to be served, unlicensed personnel (ULP)-D stated, "Residents eat lunch all on their own; they do their own meals for the most part". On June 10, 2025 at 11:15 a.m., R3 was observed in the kitchen eating macaroni and cheese. R3 stated the macaroni was from a box and was left over from their dinner the previous day. R3 stated staff would cook for the residents "if we want". R3 stated the licensee usually did not prepare or offer breakfast or lunch. R3 stated the licensee offered fettuccine for dinner the day before, but nothing else was served with it that they could remember. When asked, another resident, R2 stated they were going to McDonald's. On June 10, 2025 at 11:15 a.m., an undated weekly menu was observed posted near the kitchen. The menu included the following: -Monday Lunch- white rice and chicken, steamed vegetables and beverage of choice -Monday Dinner-grilled cheese sandwich, fresh fruit, beverage of choice -Tuesday Breakfast-omelette, whole wheat toast, beverage of choice	0 485		

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0 485	Continued From page 5 -Tues Lunch-seasoned burger, French fries, beverage of choice On June 10, 2025 at 11:55 a.m., the surveyor, along with ULP-E, observed the contents of the refrigerator and freezer in the kitchen, and noted the following: -the refrigerator lacked fresh fruits and vegetables -freezer had one bag each of spinach and okra The surveyor also observed bananas, oranges and apples on the kitchen counter, but they appeared to be over-ripe. On June 10, 2025 at 12:05 p.m., R2 stated the licensee only cooked for residents if they asked. R2 explained residents were seldom offered vegetables and the only fruit available was the apples, oranges, and bananas on the counter in the kitchen. R2 stated residents were not involved with menu planning. R2 was not aware if a menu was posted. "We don't know what were getting; we ask for what we want when we want it." On June 12, 2025, at 2:00 p.m., licensed assisted living director, (LALD)-B, stated residents in the facility were very independent and liked to make their own decisions. LALD-B affirmed the licensee understood the importance of a balanced diet and good nutrition. Owner (O)-A stated, "Going forward we will offer three meals each day and snacks consistent with the Minnesota food code, include residents in meal planning and encourage a balanced diet." The licensee's Food Service and Meal Planning policy, dated June 30, 2021, indicated the licensee would offer to provide or make available at least 3 meals daily with snacks available seven days per week according to the recommended	0 485		

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0 485	Continued From page 6 dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (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 infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 650		

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0 650	Continued From page 7 licensee failed to ensure the employee record contained the required content for two of two employees (clinical nurse supervisor (CNS)-C and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: On June 9, 2025, at 11:00 a.m., during the entrance conference, CNS-C stated employee records were maintained both in paper and electronic depending on whether it was done by the licensee in facility or Educare (an electronic education and training system to increase compliance and timely completion with staff records and education). CNS-C CNS-C was hired October 3, 2024, to provide supervision and oversite to ULPs and provide direct care services to residents admitted to the facility. CNS-C's employee record lacked documentation of: -current registered nurse (RN) license, -background study, and -orientation to assisted living regulations to include: -overview of Assisted Living statutes -review of provider's policies and procedures	0 650		

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0 650	Continued From page 8 -handling emergencies and using emergency services -reporting maltreatment of vulnerable adults or minors -assisted living bill of rights -handing of resident complaints, reporting of complaints, where to report -consumer advocacy services review of types of assisted living services the employee will provide and provider's scope of license -principles of person-centered planning/service delivery -hearing loss training (optional). ULP-D ULP-D was hired on July 1, 2023, to provide direct care services to residents admitted to the facility. ULP-D's employee record lacked documentation of annual training (at least eight hours for every 12 months of employment), in the following topics: -infection control techniques -review of provider's policies and procedures -principles of person-centered planning/service delivery -hearing loss training (optional) The record further lacked evidence of dementia training, (two hours annually). On June 12, 2025, at 2:00 p.m., licensed assisted living director (LALD)-B stated the employee records were complete, with education and training done in a timely manner, however they were unable to locate them. LALD-B explained there may be confusion having both electronic and paper records where they are stored. LALD-B stated the licensee would work on a	0 650		

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0 650	Continued From page 9 system to prevent this in the future. The Employee Records policy, undated, indicated the licensee would keep an employee record for all paid employees. Employee records would be kept up-to-date and confidential. The employee records would include: -evidence of current professional licensure, registration or certificate, if required, -records of all training and in-service education required and/or provided including record of competency testing as required, -documentation of a completed criminal background study. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 10 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. 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 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: The licensee's emergency preparedness plan (EPP), dated June 30, 2021, lacked customization to the facility, and lacked the following required content: -be updated annually, must document date of review and any updates made to the plan based on the review, -consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or	0 680		

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0 680	Continued From page 11 portion of a facility, interruption to normal supply of essential resources and medical supplies, -categorize the various probable risks/hazards by likelihood of occurrence, -take an all-hazards approach, including EIDs, as applicable, -develop strategies for addressing facility & community-based risks (i.e.: staffing surges/shortages, back-up plans): -consider duration of interruptions -identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care, -procedures for tracking of staff and residents, -identify which staff would assume specific roles in another's absence through succession planning and delegation of authority, -arrangements/contracts to re-establish utility services, -include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response, -EP includes policies and procedures (P/P) for, at minimum food and pharmaceutical supplies -EP includes P/P for alternate sources of energy, -EP includes P/P related to sewage/waste disposal, -EP includes P/P comprehensive communication plan to include means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee, -EP includes P/P in relation to an 1135 waiver On June 12, 2025, at 2:00 p.m.., licensed assistant living director (LALD)-B stated the licensee met with residents annually and as needed, but did not document annual review and updates to the facility risk assessment. LALD-B	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 12 stated this would be incorporated in the EPP plan going forward as well as having all required content included in the facilities EPP. The Emergency Preparedness Plan-Appendix Z Compliance, policy dated June 30, 2021, indicated the licensee would have in place an effective and compliant EPP, and the plan would be aligned with the Centers for Medicare Services State Operations Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=G	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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a	0 775	The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, isolated scope.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37272	A. BUILDING: _____ B. WING _____	06/12/2025

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RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

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0 775	Continued From page 13 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 10, 2025, from approximately 11:20 a.m. to 12:40 p.m., the surveyor toured the facility with owner (O)-A. During the tour, the surveyor asked O-A to open the windows in the resident sleeping rooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Resident sleeping room 1: Two windows measuring 28.5 inches clear width, 20.5 inches clear height, and 584.25 square inches total open area for each window. The windows in bedroom 1 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Surveyor explained to O-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. A headboard of a bed was situated in front of the window in resident room 3, which obstructed access to the openable area of the window for proper egress. The obstruction should be removed from in front of the window and the area	0 775		

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RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

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0 775	Continued From page 14 maintained free of objects limiting access to egress. On June 10, 2025 the surveyor explained to O-A that an immediate correction order was issued for the above findings. O-A stated they understood the requirements for egress windows and would immediately start the process of getting the windows replaced. TIME PERIOD FOR CORRECTION: Immediate	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

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0 810	Continued From page 15 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 10, 2025, at approximately 12:00 p.m., owner (O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee's FSEP failed to include the following: Record review indicated the licensee failed to provide and document adequate training to	0 810		

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	37272	A. BUILDING: _____ B. WING _____	06/12/2025

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RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

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0 810	Continued From page 16 employees on the FSEP upon hire and at least twice per year. O-A provided records of educare trainings conducted annually for employees, but these trainings did not include specific training on the facility's FSEP. Employees should be provided training upon on the FSEP upon hire and at least twice a year thereafter. During an interview on June 10, 2025, at approximately 12:20 p.m., the surveyor explained the requirements for employee trainings. O-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property 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	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 970	Continued From page 17 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility on October 9, 2020, and had diagnoses including schizophrenia and diabetes mellitus type two. R1's service plan, dated November 6, 2024, indicated R1 received services including assistance with activities of daily living (ADLs), laundry, housekeeping, blood glucose monitoring, and medication management. R1's Assisted Living Contract signed August 25, 2024, included the following language indicating waivers of liability: "20. Personal Property You agree that the Landlord may not be liable for any loss or damage to your personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond Landlord's control. You are strongly encouraged to obtain renter's insurance. 21. Overnight Guests Landlord is pleased to welcome all guests. We do, however, ask that your overnight guests observe a reasonable length of stay. You are responsible for the behavior of your guests and for any damage they may cause to the Apartment Unit or the premises of the Landlord. ..." "24. Indemnification	0 970		

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0 970	Continued From page 18 Tenant may not indemnify and hold harmless Landlord, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Tenant of the rented premises or any other part of Landlord's property, or caused wholly or in part by an act or omission of Tenant or Tenant's guests or agents." "26. Liability Landlord may not be liable to Tenant or Tenant's guests for any injury, death or property damage occurring in the Apartment Unit or on Landlord's premises unless such injury, death or property damage occurred as the result of an equipment malfunction or hazardous conditions within the building not caused by Tenant or Tenant's guests. Landlord was also not liable for any injury, death or damage occurring as the result of Tenant's receipt of health-related, supportive or other services from third party providers. Landlord may be liable to Tenant for its own negligent acts or those of its employees or agents. Unless caused by one of the afore mentioned excepted reasons, Tenant agreed to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Landlord's premises." On June 12, 2025, at 2:00 p.m., licensed assisted living director (LALD)-B stated the licensee had made several changes to the contract however understood some waivers of liability still remained which held residents residing in the facility accountable in certain circumstances. LALD-B stated the licensee would make the corrections as needed and would monitor all new and existing contracts. LALD-B state this contract was used	0 970		

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0 970	Continued From page 19 for all current residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01620 SS=D	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. (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	01620		

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01620	Continued From page 20 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. (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 reassessments not to exceed 90 calendar days from the last date of the assessment or as needed upon a change of condition for one of two residents (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 an isolated scope (when one or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01620		

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01620	Continued From page 21 R1 was admitted to the facility on October 9, 2020, and had diagnoses including schizophrenia and diabetes mellitus type two. R1's service plan, dated November 6, 2024, indicated R1 received services including assistance with activities of daily living (ADLs), laundry, housekeeping, blood glucose monitoring, and medication management. On June 9, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated the RN was responsible to complete resident assessments upon admission, within 14 days, every 90 days or with a change of a resident's condition. On June 10, 2025, at 10:00 a.m., unlicensed personnel (ULP)-D was observed assisting R1 with medication administration. R1's medical record included an assessment completed August 30, 2024. The next comprehensive nurse assessment was completed November 24, 2024, greater than 90 days (93 days) after the previous assessment. The next comprehensive nurse assessment was completed March 5, 2025, greater than 90 days (95 days) after the previous assessment. On June 12, 2025, at 2:00 p.m., licensed assisted living director (LALD)-B stated the confusion may be due to the CNS/RN responsible to complete the assessments was scheduled only one time weekly. LALD-B stated the licensee did not consider weekends or holidays, therefore thought they were in compliance. LALD-B explained the licensee would now schedule the assessments earlier (five to seven days prior) to ensure timely completion of the resident assessments. LALD-B	01620		

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01620	Continued From page 22 stated the licensee planned to make a schedule for completion of the assessments. The licensee's Assessment and Reviews and Monitoring policy, dated June 30, 2021, indicated, "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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Residential Care Nine Mile Crk
7421 13th Avenue South
Richfield, MN 55423
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37272

Risk:
License:
Expires on:
CFPM: Mohamedamin O. Abdi
CFPM #: FM125371; Exp: 10/01/2027

Inspection Info

Report Number: F1047251031
Inspection Type: Full - Single
Date: 6/9/2025 Time: 11:30 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: UNABLE TO LOCATE SANITIZER TEST STRIPS FOR CHLORINE SANITIZER SOLUTIONS
Comply By: 6/9/2025 Originally Issued On: 6/9/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: BASEMENT CHEST FREEZER HAS BUILD UP OF ICE. ICE HAS TRAPPED CRUMBS/DIRT AND IS STARTING TO BUILD UP WHERE LID SEALS TO THE BOTTOM.
Comply By: 7/9/2025 Originally Issued On: 6/9/2025

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator M. Bruess.

The establishment has a residential kitchen that serves food that is prepared that day. The kitchen has wood/composite cabinets, tiled floor, painted & tiled walls, laminate countertop, and a painted ceiling.

A two compartment sink is located in the kitchen. On sink basin is designated for hand washing. The kitchen also has a dish machine located in the kitchen.

Discussed hand washing, ware washing, employee 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 F1047251031 from 6/9/2025

Mohamedamin Abdi

Holly Sievers,

Operator

Public Health Sanitarian 2
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

Establishment Info

Residential Care Nine Mile Crk
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F1047251031
Inspection Type: Full
Date: 6/9/2025
Time: 11:30 am

Food Temperature: Product/Item/Unit: Turkey Slices**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese**; 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

Establishment Info

Residential Care Nine Mile Crk
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F1047251031
Inspection Type: Full
Date: 6/9/2025
Time: 11:30 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 172 Degrees F.
Comment:
Violation Issued?: No