Electronically Delivered

March 24, 2026

Licensee
Crescent Group Home LLC
2566 Sunbow Lane
New Brighton, MN 55112

RE: Project Number(s) SL36931016

Dear Licensee:

On March 3, 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 on December 12, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 12, 2025 survey.

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

At the time of this follow-up survey completed on March 3, 2026, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36931	A. BUILDING: _____ B. WING _____	R 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT GROUP HOME LLC	2566 SUNBOW LANE NEW BRIGHTON, MN 55112

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36931016-1 On March 2, 2026, through March 5, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 12, 2025. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following order was issued.	{0 000}		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract.	{0 485}		

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{0 485}	Continued From page 1 This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during this survey.	
{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:	{0 650}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 2 (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}	Not reviewed during this survey.	
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for	{0 780}		

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{0 780}	Continued From page 3 sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	{0 800}		

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{0 800}	Continued From page 4 This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{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 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.	{0 810}		

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{0 810}	Continued From page 5 This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
0 830 SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to submit a plan review application for installation of a new egress window. This had the potential to directly affect one resident and more than a limited number of staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	0 830		

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0 830	Continued From page 6 situation has occurred only occasionally). The findings include: On March 2, 2026, at 10:05 a.m., the surveyor toured the building with manager (M)-K. During the tour, the surveyor observed a new egress window had been installed in occupied resident bedroom three. During the tour interview, M-K verified this new egress window was installed as part of a survey correction. On March 3, 2026, record review verified a plan review application had not been submitted to Minnesota Department of Health Engineering Services for this project. On March 3, 2026, the surveyor emailed the licensee and requested an update on the status of this required plan review application. As of March 5, 2026, a response was not received. Previously, on December 12, 2025, the surveyor emailed the licensee instructions for submitting a plan review application to Minnesota Department of Health Engineering Services for the egress window replacement. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	{0 970}		

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{0 970}	Continued From page 7 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.	
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if	{01530}		

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{01530}	Continued From page 8 issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.	
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	{01940}		

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{01940}	Continued From page 9 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.	
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}	Not reviewed during this survey.	

Electronically Delivered

January 22, 2026

Licensee
Crescent Group Home LLC
2566 Sunbow Lane
New Brighton, MN 55112

RE: Project Number(s) SL36931016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 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 . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

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CRESCENT GROUP HOME LLC	2566 SUNBOW LANE NEW BRIGHTON, MN 55112

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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: SL36931016-0 On December 8, 2025, through December 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license. An immediate correction order was identified on December 11, 2025, issued for SL36931016-0, tag identification 0775 at a scope and level of pattern, level three (H). The licensee took mitigating actions, however, the correction order remains at a scope and level of H.	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.	
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

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	36931	A. BUILDING: _____ B. WING _____	12/12/2025

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0 485	Continued From page 1 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living monthly base fee for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents 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: R1 R1 was admitted to licensee on July 22, 2021,	0 485		

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0 485	Continued From page 2 with a diagnosis of major depressive disorder. R1's Resident Contract for Assisted Living dated March 1, 2025, indicated all services listed on Attachment A were included in the monthly base fee. Attachment A included at least three meals daily with snacks available seven days per week. R2 R2 was admitted to licensee on January 17, 2025, with diagnosis of generalized anxiety disorder. R2's Resident Contract for Assisted Living dated January 17, 2025, indicated all services listed on Attachment A were included in the monthly base fee. Attachment A included at least three meals daily with snacks available seven days per week. On December 9, 2025, at 12:11 p.m., licensed assisted living director/registered nurse (LALD/RN)-C acknowledged the contract included the meals with the base monthly fee and indicated the licensee would correct the contract. The licensee's undated Assisted Living - Minimum Meal Requirements policy indicated the licensee would provide three nutritionally balanced meals per day and at least one nutritious snack daily however the policy did not indicate the three meals daily with snacks could not be included in the base monthly fee per statue. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 650	Continued From page 3	0 650		
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 licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-A, ULP-B) who were employed greater than one year. 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	0 650		

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0 650	Continued From page 4 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: ULP-A was hired on November 9, 2021. ULP-A's employee record lacked evidence of completed annual performance reviews for 2023, 2024, and 2025. ULP-B was hired on October 3, 2022. ULP-B's employee record lacked evidence of completed annual performance reviews for 2023, 2024, and 2025. On December 9, 2025, at 8:28 a.m., licensed assisted living director/registered nurse (LALD/RN)-C stated the annual performance reviews should be in the employee record. On December 9, 2025, at 1:15 p.m., LALD/RN-C provided to the surveyor, the licensee's supervision of nursing delegated tasks for ULP-A and ULP-B; and indicated they were annual performance reviews. LALD/RN-C acknowledged the supervisions did not indicate areas needed for improvement and additional training needs. The licensee's Performance Evaluation policy dated August 1, 2021, indicated a formal performance evaluation would be conducted for all staff that provided assisted living services at least annually. The policy indicated the performance evaluation would address areas of improvement needed and any additional	0 650		

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0 650	Continued From page 5 education or training needs for the staff member. Additionally, the policy indicated documentation of the annual performance evaluation would be maintained in the personnel file. 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 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.	0 680		

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0 680	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - subsistence needs for staff and patients; - policies and procedures for volunteers; and - methods for sharing information. On December 8, 2025, at 1:26 p.m., licensed assisted living director/registered nurse (LALD/RN) acknowledged the missing content in the EPP and stated the items should have been available. On December 9, 2025, at 11:41 a.m., LALD/RN stated the owner was looking at getting additional information needed for the EPP. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff	0 680		

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0 680	Continued From page 7 during periods of an emergency disaster the disrupted services. The policy referenced CMS (Centers for Medicare and Medicaid Services) State Operations Manual Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=H	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 Minnesota State Fire Code (MSFC) in Minnesota Rules, chapter 7511. This had the potential to directly affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 11, 2025, at 12:20 p.m., the surveyor toured the facility with unlicensed	0 775		

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0 775	Continued From page 8 personnel (ULP)-E and unlicensed personnel (ULP)-G. The egress windows in resident sleeping rooms were opened by ULP-E and measured by the surveyor. The windows in occupied resident sleeping room three did not meet the minimum requirements for safe egress. The clear open area of both windows measured 26 inches width, 22.5 inches height, with a total clear area of 585 square inches. The windows in sleeping room three did not meet the minimum requirements for total openable area. One window in each resident sleeping room must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). During the facility tour interview, ULP-E and ULP-G verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate Additional survey findings: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 11, 2025, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 9 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	0 780		

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0 780	Continued From page 10 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 11, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800		

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0 800	Continued From page 11 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 11, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping 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.	0 810		

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0 810	Continued From page 12 (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 and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 11, 2025, for the specific violations related the physical environment under Minnesota	0 810		

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0 810	Continued From page 13 Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language that waived the licensee's liability for the health, safety, or personal property of a resident for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents 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: R1 R1 was admitted to licensee on July 22, 2021, with a diagnosis of major depressive disorder.	0 970		

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0 970	Continued From page 14 R1's Resident Contract for Assisted Living dated March 1, 2025, indicated under provisions related to liability, the licensee would not be responsible for any damage or injury suffered by the resident or the resident's property that was not caused by the licensee. R2 R2 was admitted to licensee on January 17, 2025, with a diagnosis of generalized anxiety disorder. R2's Resident Contract for Assisted Living dated January 17, 2025, indicated under provisions related to liability, the licensee would not be responsible for any damage or injury suffered by the resident or the resident's property that was not caused by the licensee. On December 9, 2025, at 11:47 a.m., licensed assisted living director/registered nurse (LALD/RN)-C stated the licensee was aware they could not have any waiver of liability in the contract. LALD/RN stated the licensee had changed their contract previously and had used information provided on the Minnesota Department of Health (MDH) website. LALD/RN-C confirmed the last signed contracts were the most current contract. LALD/RN-C acknowledged the contract did indicate they would not be responsible, but the licensee may be responsible for injury or damage of resident property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36931	A. BUILDING: _____ B. WING _____	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT GROUP HOME LLC	2566 SUNBOW LANE NEW BRIGHTON, MN 55112

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01530	Continued From page 15	01530		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on	01530		

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01530	Continued From page 16 topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees received two (2) hours of initial training on topics related to mental illness and de-escalation for direct care staff as required for three of three unlicensed personnel ((ULP)-A, ULP-B, ULP-E, ULP-F). 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: ULP-A On December 9, 2025, at 8:12 a.m., the surveyor observed ULP-A assist resident (R1) with medication administration. ULP-A was hired on November 9, 2021, as a home health aide to provide direct care to residents. ULP-A's employee record lacked evidence of any mental illness and de-escalation training prior to December 8, 2025 (which was after the initiation of survey).	01530		

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01530	Continued From page 17 ULP-B ULP-B was hired on October 3, 2022, as a home health aide to provide direct care to residents. ULP-B's employee record lacked evidence of any mental illness and de-escalation training prior to December 8, 2025 (which was after the initiation of survey). On December 9, 2025, at 8:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-C stated the licensee had trained the staff on each residents' mental illness and the signs and symptoms they are supposed to look for. LALD/RN-C stated the licensee was aware of the new statue that had required mental illness training. On December 9, 2025, at 8:57 a.m., ULP-A stated the licensee had an in-person meeting on October 20, 2025, where they were educated on mental health and other topics. ULP-A stated the nurse had educated on mental health needs along with signs and symptoms. The surveyor reviewed the meeting minutes from October 20, 2025, which indicated a review of current residents' health, behaviors, and care needs. The meeting minutes did not contain any evidence of mental illness and de-escalation training. On December 9, 2025, at 9:20 a.m., ULP-F showed the surveyor, the licensee's online education training for staff. ULP-F showed the surveyor the training transcript for ULP-E. The surveyor observed ULP-E was assigned to Mental Illness and Response Strategies course on December 8, 2025, but this had not been started yet. ULP-F then showed the surveyor ULP-F's online education transcript, which	01530		

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01530	Continued From page 18 included a course on Mental Illness that was assigned on December 8, 2025. ULP-F's online education transcript indicated the Mental Illness course had not been completed. The surveyor observed ULP-F opening the course, which indicated it would only show slides that had been previously viewed. On December 9, 2025, at 10:12 a.m., ULP-F showed the surveyor their online education transcript again to show the surveyor they had completed the course, Mental Illness. The surveyor observed the course credit was forty-five minutes (does not meet the required training time). ULP-F had clicked on the course for more information, the surveyor observed the course was marked as complete however the course time spent indicated zero. On December 9, 2025, at 10:58 a.m., LALD/RN-C confirmed the licensee did not have a policy on the requirements for mental illness and de-escalation training. LALD/RN-C stated the licensee had just ordered a policy regarding mental illness training from a consultant company. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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01940	Continued From page 19 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include a statement of general treatment services to be provided on the service plan for one of two residents (R2) with a treatment. 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	01940		

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01940	Continued From page 20 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: R2 was admitted to licensee on January 17, 2025, with a diagnosis of generalized anxiety disorder. R2's Service Plan (Waiver) - Addendum to Contract dated January 17, 2025, indicated R2 received assistance with medication administration. R2's service plan lacked a statement of the treatment services provided for oxygen delivery. R2's order dated October 31, 2025, indicated R2 was to receive oxygen, 2 liters per minute (lpm) via nasal canula at rest and 4 lpm with activity continuously with portability. R2's medication administration record (MAR) dated December 2025, indicated staff assisted with the administration of oxygen to use continuously at 2 lpm at rest and 4 lpm during activities, three times per day (morning, midday, and at bedtime) from December 1, 2025, to December 9, 2025. On December 11, 2025, at 4:08 p.m., licensed assisted living director/registered nurse (LALD/RN)-C stated they were aware of the need to have all treatment services on the residents' service plans. On December 11, 2025, at 4:37 p.m., clinical nurse supervisor (CNS)-D confirmed the licensee had started to provide oxygen treatment services	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 21 following R2's hospitalization on October 31, 2025. CNS-D stated the licensee had been waiting for the county before updating the licensee's service plan with R2. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated a treatment delegated by the nurse would be specified in the service plan. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include a description of the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R2) with oxygen. 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	02310		

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02310	Continued From page 22 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 8, 2025, at 11:11 a.m., during a facility tour, the surveyor observed R2's room number three. R2's room had two oxygen cylinders standing upright on the floor and were not stored in a rack, stand or secured with chains. The oxygen cylinders were not in use by the resident. R2 was admitted to licensee on January 17, 2025, with a diagnosis of generalized anxiety disorder. R2's Service Plan (Waiver) - Addendum to Contract dated January 17, 2025, indicated R2 received assistance with medication administration. On December 8, 2025, at 11:33 a.m., licensed assisted living director/registered nurse (LALD/RN) stated the oxygen tanks should have been on the oxygen stands to be more secured; and they would have to train staff more on storage of oxygen. LALD/RN stated the resident had thought they were going out of the facility. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. Medical gas cylinders would be considered "in use" and not counted as storage if they were	02310		

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02310	Continued From page 23 being used by a patient, secured to equipment to be ready for immediate use, or placed in a patient room for immediate patient use. The licensee's undated Oxygen Storage & Safety Materials policy indicated cylinders were to be stored upright and secured with a rack, stand or chain. Also, the policy indicated the cylinders could not be stored on floors or in resident rooms unless they were in use. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

Crescent Group Home LLC
2566 Sunbow Lane
New Brighton, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 36931

Risk:
License:
Expires on:
CFPM: Ethan N. Barrera
CFPM #: FM120593; Exp:

Inspection Info

Report Number: F1043251297
Inspection Type: Full - Single
Date: 12/9/2025 Time: 2:23:23 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection was completed with Rhawnie Quinehan as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, same day food service, cleaning, vomit/fecal procedures, test kits, food storage, and food handling procedures.

TEMPERATURE (F)
REACH IN COOLER: YOGURT 41, MILK 41, CHEESE 41

UTENSIL SURFACE TEMPERATURE (F)
DISH MACHINE: 180

This facility has a residential kitchen with residential equipment, wooden cabinetry, laminated flooring, smooth walls, and textured ceilings. Conditions of equipment and physical facility will be monitored during future inspections - must be brought up to code if at such time they are found to be a concern or risk of contamination.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1043251297 from 12/9/2025

Ethan N. Barrera

Blia Lor,

Food Manager

Public Health Sanitarian 1
651-355-0641
blia.lor@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36931016-0	**Date:** December 11, 2025
Facility Name: CRESCENT GROUP HOME LLC	
Facility Address: 2566 SUNBOW LANE, NEW BRIGHTON, MN 55112	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Pattern **TIME PERIOD OF CORRECTION:** Immediate

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments:
   - The means of egress from the back exit door to the public right-of-way was obstructed. A path had not been maintained free of snow. Additionally, potted plants were stored in front of this exit door.
   - The exit door for occupied bedroom four was obstructed by snow at the top of the landing on the exterior of the building.
   - One copy of the posted emergency evacuation floor plan labeled the door in the attached garage inappropriately as an exit. Unlicensed personnel (ULP)-G stated that the floor plans had been updated, and this was an outdated copy.

3. In buildings that contain a fuel-burning appliance or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: Carbon monoxide alarms were not installed within ten feet of resident bedrooms one, three, and four. A gas water heater was installed in the building.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: An extension cord was used to supply power in occupied resident bedroom one.

5. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: There was trash inside the container designated for smoking material disposal.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments:
   - The smoke alarm installed outside occupied resident bedroom 2 in the basement was not interconnected with the wireless dwelling unit smoke alarm system.
   - There were random battery operated single-station smoke alarms installed throughout the building. Unlicensed personnel (ULP)-E stated that these smoke alarms were extras and not part of the dwelling unit wireless interconnected smoke alarm system.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Two (2) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: There was an accumulation of ice and icicles on the building gutter system, creating a safety risk to the building occupants.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

Comments: The occupied resident bedroom in the basement was not accurately identified. The number posted at the resident bedroom door did not match the posted floor plans. The number identifiers installed on or at the resident bedroom doors need to correspond accurately with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency.

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

   Comments: The fire safety and evacuation plan (FSEP) failed to provide site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.
   Record review of the available documentation indicated the following:
   - A portable fire extinguisher location was inaccurately described on the safety information poster displayed on the bulletin board in the dining room. This poster directed the building occupants to a fire extinguisher installed at the entrance door. Unlicensed personnel (ULP)-G stated this fire extinguisher had been removed. Additionally, portable fire extinguisher installation locations were blank in the fire extinguisher policy dated May 13, 2025.
   - The FSEP included fire safety instructions based on a RACE ((Remove, Alarm, Confine, Extinguish/Evacuate) *template from a third party and inaccurately referenced pull fire alarms.*
   -The fire evacuation policy dated May 13, 2025, was a template from a third party and the employee responsibilities were blank.

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

   Comments: Record review of the available documentation indicated the fire safety and evacuation plan failed to include site specific instructions for residents. The procedures were from a third party.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: Record review of the available documentation indicated the fire safety and evacuation plan (FSEP) failed to include evacuation procedures for the individualized unique needs of residents. The fire evacuation policy dated May 13, 2025, referenced evacuation acuity levels but the individualized resident evacuation procedures were not included with the FSEP.