Electronically Delivered

February 26, 2026

Licensee
Hopeville Homes
4801 78th Lane North
Brooklyn Park, MN 55443

RE: Project Number(s) SL39424016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39424	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEVILLE HOMES	4801 78TH LANE NORTH BROOKLYN PARK, MN 55443

(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: SL39424016-0 On January 20, 2026, through January 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license.	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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control related to handwashing and glove use for two of two unlicensed personnel ((ULP)-A, ULP-G). The deficient practice had the potential to affect residents, employees, 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: ULP-A ULP-A was hired on November 8, 2023.	0 510		

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0 510	Continued From page 2 ULP-A's Skill Competency Personal Protective Equipment (PPE) dated December 28, 2023, indicated ULP-A passed competency evaluation by a registered nurse (RN) for handwashing and glove use. On January 21, 2026, at 8:32 a.m., the surveyor observed ULP-A standing in the common kitchen area wearing gloves. ULP-A stated they washed their hands prior to donning (put on) gloves. ULP-A prepared resident (R4)'s medications in a disposable cup while touching and reviewing R4's medications on the computer. ULP-A went to R4's room where they assisted with placing R4's oral medication into R4's mouth. ULP-A left R4's room while wearing the same gloves. ULP-A doffed (removed) the gloves but did not perform hand hygiene after. The surveyor observed ULP-A touching the computer to document the medications administered, threw empty blister packs in the garbage, put R4's medication basket back into the medication closet and lock the door using a key. ULP-A then went into the common kitchen to put dishes in the dishwasher, grabbed a dishrag to rinse the sink and wiped the counter without using soap. On January 21, 2026, at 8:36 a.m., ULP-A stated they should have performed hand hygiene before and after glove use. On January 21, 2026, at 8:44 a.m., RN-F stated they expected staff to perform hand hygiene before and after a medication pass; and before and after the use of gloves which should be worn during cares on residents. RN-F stated it was an infection control concern if staff did not perform hand hygiene. ULP-G	0 510		

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0 510	Continued From page 3 ULP-G was hired on August 20, 2021. On January 22, 2026, at 11:44 a.m., ULP-G stated the nurse had taught them on handwashing and glove use. On January 22, 2026, at 12:01 p.m., the surveyor observed ULP-G use hand sanitizer, don gloves, flush R2's gastrostomy tube with water, and connect R2's enteral feeding to R2's gastrostomy tube via kangaroo pump. After the procedure, the surveyor observed ULP-G doff gloves, remove supplies from R2's room and throw supplies away in the common kitchen garbage. ULP-G did not perform hand hygiene after doffing gloves. ULP-G put their hands in their pockets, then went to the common living room, where ULP-G fluffed a pillow on the couch. On January 22, 2026, at 1:32 p.m., clinical nurse supervisor (CNS)-D stated staff needed to perform hand hygiene before and after cares, and before and after glove use. CNS-D stated all staff had been trained in handwashing and glove use. The licensee's Standard Precautions for All Health Care Workers policy dated July 16, 2025, indicated to wash hands but did not indicate when staff should perform hand hygiene or a procedure for hand washing. The policy indicated glove use would be required when cleaning reusable equipment; direct contact with blood, body fluids, mucous membranes, and non-intact skin; handling of items soiled with blood; or handling equipment contaminated with blood or body fluids. The policy indicated thorough hand washing would be required after the removal of gloves. The policy referenced 144A Statute and not 144G Statute.	0 510		

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0 510	Continued From page 4 The Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infections Agents in Healthcare Settings updated September 2024, on page 129, table 4, indicated recommendations for application of standard precautions for the care of all patients in all healthcare settings included the following: - Hand hygiene recommendations after touching blood, body fluids, secretions, excretions, contaminated items, immediately after removing gloves, and between patient contacts; and - Personal protective equipment (PPE) gloves recommendations for touching blood, body fluids, secretions, excretions, contaminated items, for touching mucous membranes, and nonintact skin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 650		

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0 650	Continued From page 5 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 observation, 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). 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 January 21, 2026, at 8:32 a.m., the surveyor observed ULP-A administer medications to R4. ULP-A was hired on November 8, 2023. ULP-A's record lacked documentation of competency evaluations by a registered nurse as follows:	0 650		

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0 650	Continued From page 6 - appropriate and safe techniques in personal hygiene and grooming to include hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; and - medication administration through a gastrostomy tube. ULP-B ULP-B was hired on February 19, 2024. ULP-B's record lacked documentation of competency evaluations by a registered nurse as follows: - appropriate and safe techniques in personal hygiene and grooming to include hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; and - medication administration through a gastrostomy tube. On January 20, 2026, at 3:01 p.m., ULP-B stated they were trained and had to return demonstration back to the nurse for the gastrostomy tube and personal cares that included bathing, haircare, dressing, oral cares, and hearing aids. On January 21, 2026, at 8:36 a.m., ULP-A stated they were trained and had to return demonstration back to the nurse for the gastrostomy tube and personal cares that included bathing, haircare, dressing, oral cares, and hearing aids. On January 21, 2026, at 8:58 a.m., registered nurse (RN)-F stated they completed competency evaluations on all staff for personal cares that included bathing, haircare, dressing, oral cares,	0 650		

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0 650	Continued From page 7 and hearing aids. On January 22, 2026, at 11:17 a.m., licensed assisted living director (LALD)-C stated they knew the licensee had completed competency evaluations of all staff for personal cares, but they could not locate them in the record or at the office. LALD-C stated they had recently moved office locations and believed they had gotten lost in the transition. On January 22, 2026, at 11:27 a.m., clinical nurse supervisor (CNS)-D and RN-F stated they had taught all staff on medication administration through a gastrostomy tube. On January 22, 2026, at 12:15 p.m., CNS-D and RN-E confirmed the personnel records did not contain competency evaluations for medication administration through a gastrostomy tube. CNS-D and RN-F stated they were aware personnel records needed to have all training and competency evaluations completed but thought the documentation was lost when the licensee had moved offices. CNS-D and RN-F stated Educare (common online training) did not have education material on administering medications through a gastrostomy tube, as they had to create their own education material. The licensee's Personnel Records policy dated August 21, 2025, indicated personnel records for an employee shall include records of competencies. The policy referenced 144A Statute and not 144G Statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. 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).	0 660		

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0 660	Continued From page 9 The findings include: The licensee's Facility TB Risk Assessment dated January 30, 2025, was completed on October 30, 2025. The assessment identified the national rate was 2.5 percent and the Minnesota rate was 2.3 percent for 2022. The assessment form and data used to complete the incidence of TB was not current information at the time the assessment was completed. On January 21, 2026, at 11:30 a.m., licensed assisted living director (LALD)-C confirmed they completed the licensee's TB risk assessment annually. LALD-C stated they would search online every year for the incidence of TB for the national and Minnesota rates. LALD-C confirmed the data used was from 2022 and was not current when they completed the licensee's TB risk assessment. The licensee's Tuberculosis Screening policy dated November 1, 2025, indicated TB testing and periodic evaluation on all employees would be based on the licensee's risk assessment. The policy referenced 144A Statute and not 144G Statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 10 (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: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan 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 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	0 680		

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0 680	Continued From page 11 portion or all of the residents). The findings include: The licensee's EP plan dated July 1, 2025, lacked the following required content: -evidence that the missing resident plan was reviewed at least quarterly by the licensed assisted living director (LALD) and the clinical nurse supervisor (CNS); -policies to address the provision of food, water, medical supplies, and pharmaceutical supplies; -policies for use and integration of volunteers; -policies to address the system of medical documentation that preserves resident information, protects confidentiality and secures and maintains availability of records; and -exercises to test the EP plan at least twice per year. On January 22, 2026, at 12:04 p.m., CNS-D stated the missing resident plan was updated in the quarterly quality meetings. On January 22, 20216, at 12:16 p.m., LALD-C stated the missing resident plan was not reviewed as part of the quarterly quality meeting. LALD-C stated they were not affiliated with a regional coalition and have not conducted disaster drills over the past year. LALD-C stated they did not have a plan for provision of food, medication or medical supplies, or the use of volunteers and would address those issues with their next EP plan update. The Minnesota Rule 4659.0110, Subpart 4 indicated the LALD and CNS would review the missing resident plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 12 The licensee's Emergency Preparedness policy revised July 30, 2025, indicated [licensee] would have an identified plan in place to assure the safety and well being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=C	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1/21/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 14 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 15 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1/21/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident	0 900		

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0 900	Continued From page 16 promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written contract with the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 22, 2026, at 12:01 p.m., the surveyor observed unlicensed personnel (ULP)-G flush R2's gastrostomy tube with water and connect R2's enteral feeding to R2's gastrostomy tube via kangaroo pump. R2 was admitted to the licensee on April 15,	0 900		

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0 900	Continued From page 17 2023. R2's Assisted Living Contract dated August 23, 2021, indicated the contract was for a different facility address. R2's record lacked a contract for the current facility address where R2 resided and received assisted living services. On January 21, 2026, at 10:07 a.m., licensed assisted living director (LALD)-C confirmed R2 moved into the facility on April 15, 2023. On January 21, 2026, at 11:00 a.m., LALD-C confirmed the only contract signed for R2 was completed August 23, 2021. LALD-C stated the licensee did not complete another contract when R2 moved into the facility from a different facility owned by the same owner. LALD-C stated the licensee was not aware they needed to have the resident sign a new contract for each facility when they transferred a resident from one location to another location. The licensee's Client Admission Process policy dated December 10, 2025, did not indicate an assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. The policy referenced 144A Statute and not 144G Statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the	01060		

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01060	Continued From page 18 facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 19 a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R2) who had an emergency relocation. 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: R2 was admitted to the licensee on April 15, 2023. R2's Resident Notes - One Resident dated December 1, 2025, to January 21, 2026, indicated on December 13, 2025, at 6:21 p.m., R2 was taken to the hospital in the morning due to stomach pain. R2's record lacked documentation that R2, R2's legal representative, and R2's designated representative received a written notice with all the required content for an emergency relocation. On January 22, 2026, at 1:58 p.m., registered nurse (RN)-F stated R2 was sent to hospital due	01060		

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01060	Continued From page 20 to abdominal pain. RN-F stated they called R2's daughter to notify them of R2 being sent to hospital. On January 22, 2026, at 1:59 p.m., clinical nurse supervisor (CNS)-D stated the licensee does not provide any written notices when a resident goes to the emergency room; and the licensee would only provide a written notice if a resident were to be admitted to hospital. CNS-D stated they had misunderstood the Statute. The licensee's Assisted Living Contract Terminations policy dated June 11, 2025, indicated in the event of an emergency relocation, the facility must provide a written notice that contained all the requirements as indicated under 144G Statute. The policy indicated the written notice must be delivered as soon as practical to the resident, legal representative, and designated representative; and for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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)	01530		

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01530	Continued From page 21 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 topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received two (2) hours of initial training on topics related to	01530		

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01530	Continued From page 22 mental illness and de-escalation for direct care staff as required for two of two unlicensed personnel ((ULP)-A, ULP-B). 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: ULP-A ULP-A was hired on November 8, 2023, and began providing assisted living services. ULP-A's personnel record included an Educare (online training) transcript dated January 20, 2026, indicating ULP-A had completed 45 minutes (0.75 hours) of mental illness training on November 10, 2023, and 45 minutes of mental illness training on March 4, 2025. ULP-B ULP-B was hired on February 19, 2024, and began providing assisted living services. ULP-B's personnel record included an Educare transcript dated January 20, 2026, indicating ULP-B had completed 45 minutes of mental illness training on February 23, 2024. ULP-A and ULP-B's personnel records lacked the required two hours of initial training on mental illness and de-escalation topics.	01530		

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01530	Continued From page 23 On January 22, 2026, at 1:58 p.m., clinical nurse supervisor (CNS)-D stated they were aware of the two-hour requirement for mental health training and were unsure why all the courses were not completed. On January 22, 2026, at 2:00 p.m., licensed assisted living director (LALD)-C stated they would review the online training assignments to ensure all courses were assigned and completed. On January 22, 2026, at 2:19 p.m., LALD-C stated they did not have a policy addressing mental health training and de-escalation techniques. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of one resident (R2). 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: R2 was admitted to the licensee on April 15, 2023. R2's Service Plan (Wavier) - Addendum to Contract dated December 27, 2023, indicated R2 received assistance with medication administration and enteral (intake of food via the gastrointestinal tract) gastrostomy tube (surgical placed device to give direct access to the stomach) feeding. LIDOCAINE PATCHES R2's Med Admin Summary - Actual - Month (MAR) dated January 2026, indicated lidocaine 5 percent (%) patches, apply one patch to skin once daily at 8:00 a.m., ok to cut the patch in half and apply to the anterior aspect of both knees, keep on for 12 hours and remove at 8:00 p.m. The MAR indicated this medication was administered three times at 8:00 a.m. and removed eight times at 8:00 p.m. from January 1,	01760		

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01760	Continued From page 25 2026, to January 21, 2026. The documentation did not match up for the administration of the patch at 8:00 a.m. and removal of the patch at 8:00p.m. On January 22, 2026, at 2:49 p.m., licensed assisted living director (LALD)-C stated R2's lidocaine patch administration did not make sense after they reviewed the MAR with the surveyor for the administration and removal of the lidocaine patches. LALD-C stated the MAR did not reflect what was administered by the staff. CHLORHEXIDINE R2's Med Admin Summary - Actual - Month (MAR) dated January 2026, indicated chlorhexidine 0.12% Solution, swish 15 milliliters (ml) by mouth twice daily for 30 seconds, then spit. The MAR indicated this medication was administered twice a day at 8:00 a.m. and 8:00 p.m., by five different staff (unlicensed personnel (ULP)-A, ULP-B, ULP-E, ULP-G, ULP-H) from January 1, 2026, to January 21, 2026. On January 22, 2026, at 11:44 a.m., ULP-G stated they do not administer R2's chlorhexidine since R2 could not spit this medication out. (ULP-G had documented the administration of R2's chlorhexidine on the MAR for the month of January 2026). On January 22, 2026, at 12:28 p.m., LALD-C stated they tried to administer R2's chlorhexidine, but it was very difficult, so they used an oral swab instead. On January 22, 2026, at 12:28 p.m., registered nurse (RN)-F stated they were aware of the medication being administered differently than the instructions indicated on the MAR. RN-F stated	01760		

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01760	Continued From page 26 they considered this to be a medication error as the medication administration was documented differently than how it was being administered. On January 22, 2026, at 12:28 p.m., clinical nurse supervisor (CNS)-D stated R2 could not swish and spit the chlorhexidine. CNS-D stated the licensee should get new orders to change R2's chlorhexidine to use a mouth swab instead of the resident to swish and spit the medication. GASTROSTOMY TUBE MEDICATIONS R2's Individualized Medication Management Plan (IMMP) dated November 30, 2025, indicated the following instructions for medication administration through R2's gastrostomy tube; stop G-tube, remove from resident, flush with 30 milliliters (ml) of water, crush all medications that can be crushed, mix with water and administer through G-tube, after administration flush with 30 ml of water again, then cleanse syringe with water and place in bag. R2's Med Admin Summary - Actual - Month (MAR) dated January 2026, indicated R2 received the following medications via gastrostomy tube (G-tube) at 8:00 a.m.: - aspirin 81 milligrams (mg) chew tablet, take one tablet per G-tube once daily; - baclofen 10 mg tablet, take one tablet by G-tube twice daily; - calcium antacid 500 mg chew, take one tablet by G-tube daily; - citalopram 10 mg tablet, take one tablet by G-tube daily; - clonidine 0.1 mg tablet, take two tablets per G-tube once daily; - metoprolol tartrate 50 mg tablet, take one tablet twice a day; - oyster shell 500 mg tablet, take one tablet per	01760		

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01760	Continued From page 27 G-tube once daily; - phenytoin CHW 50 mg tablet, crush five tablets into a fine powder and disperse in 10 to 30 ml of purified water prior to administration and give per G-tube once daily; and - vitamin C 500 mg tablet, take one tablet per G-tube once daily. R2's Med Admin Summary - Actual - Month (MAR) dated January 2026, indicated R2 received the following medications via G-tube at 8:00 p.m.: - baclofen 10 mg tablet, take one tablet by G-tube twice daily; - clonidine 0.1 mg tablet, take two tablets per G-tube once daily; - lisinopril 5 mg tablet, take one tablet per G-tube every evening; - metoprolol tartrate 50 mg tablet, take one tablet twice a day; and - baclofen 5 mg tablet, take one tablet by G-tube every evening along with 10 mg for total dose of 15 mg. On January 21, 2026, at 3:10 p.m., ULP-E stated they would prepare R2's 8:00 p.m. medications at 7:30 p.m. by crushing the medications together and then mixing the medications with the water and would wait approximately 30 minutes for the medications to dissolve before administration through R2's G-tube. On January 22, 2026, at 11:44 a.m., ULP-G stated they would crush R2's medications together with 10 ml of water; let the medications sit for a while to dissolve before the administration; and then they would flush the G-tube with another 30 ml of water after the administration. ULP-G showed the surveyor a large automatic pill crusher that could fit all	01760		

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01760	Continued From page 28 medications and again showed the surveyor they put all medications together to crush at once. On January 22, 2026, at 1:03 p.m., the surveyor asked RN-F if they had trained staff to crush and mix all medications together when R2 had their medications administered through the G-tube. RN-F stated no and then stated they think the liquid medication is separate; and then told the surveyor to wait a second. The surveyor then observed RN-F talking to CNS-D but did not respond further to the surveyor's question. The licensee's Medication Administration by Unlicensed Personnel dated November 1, 2025, indicated ULPs would check the five rights for safely giving medication; and would document the medication administration or any difficulty in taking the medication after the task was performed. The policy indicated medications via G-tube would be crushed and mixed with 5 ml of water if not in elixir (liquid) form and then flushed with 50 ml of water. The policy indicated multiple medications via G-tube should be given one at a time. The policy referenced 144A Statute and not 144G Statute. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.	01830		

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01830	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every twelve months for one of one resident (R2). 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: R2 was admitted to the licensee on April 15, 2023. R2's Service Plan (Wavier) - Addendum to Contract dated December 27, 2023, indicated R2 received assistance with medication administration and enteral (intake of food via the gastrointestinal tract) gastrostomy tube (surgical placed device to give direct access to the stomach) feeding. R2's Provider Contact dated January 16, 2024, identified as R2's orders by clinical nurse supervisor (CNS)-D, indicated R2 was to keep urology appointment for evaluation on catheter; and a Cologuard (colon cancer) screening was sent. The form had a printed attached active medication list with treatments identified by the licensee; however, this was not signed by a provider. The provider did not acknowledge to	01830		

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01830	Continued From page 30 continue with all active medications and treatments as identified by the licensee. R2's record lacked authenticated current prescription orders for all medications managed by licensee. On January 21, 2026, at 1:56 p.m., registered nurse (RN)-F stated R2's orders had not changed since they moved into the facility. On January 22, 2026, at 2:58 p.m., licensed assisted living director (LALD)-C stated the doctors just send orders so the licensee did not get annual orders for their residents. The licensee's Medication Orders policy dated October 10, 2025, indicated verbal and telephone orders would be taken by licensed professionals and would be written down and read back for verification. Also, the policy indicated that staff would verify with the physician any incomplete, illegible or unclear medication orders prior to the administration of the medication. The policy did not include any information on annual orders. The policy referenced 144A Statute and not 144G Statute. The licensee's Medication Administration policy dated August 21, 2025, indicated a licensed nurse would be responsible for the assessment of medications to assure all medications were current and ordered by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		

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01950	Continued From page 31	01950		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and 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) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident (R2) who had an enteral feeding, gastrostomy tube (G-tube) water flushes, and oral dietary needs. 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	01950		

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01950	Continued From page 32 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 21, 2026, at 12:07 p.m., the surveyor observed unlicensed personnel (ULP)-A get a new 1,200 milliliter (ml) enteral feeding pump bag set with tubing and fill the bag with Jevity 1.2 Cal (type of enteral formula). ULP-A stated they were told to put the whole bottle in the bag and then prime the tubing. The surveyor observed kangaroo pump was set at a rate of 100 ml per (/) hour (hr). ULP-A disconnected the enteral feeding, connected a 60 ml syringe and poured purified water into the syringe and let the water go through the enteral tube by gravity (method used to deliver formulas). ULP-A stated they were not flushing (method used to clean the feeding tube to prevent clogging and maintain hygiene after each feeding, medication or as directed by healthcare provider) R2's G-tube, just giving water to hydrate. ULP-A stated they give R2 one 16 oz (473 ml) bottled water every day at noon. ULP-A connected R2's enteral feeding to R2's G-tube via kangaroo pump at a rate of 100 ml/hr after giving water. On January 22, 2026, at 12:01 p.m., upon entry to R2's room, the surveyor observed R2's enteral feeding was disconnected from R2's G-tube. The enteral tubing had a full bag of formula already prepared and was actively dripping onto the floor from the end of the tubing. ULP-G connected a 60 ml syringe and poured half of a 16 oz bottle of purified water (approximately 236 ml) into the syringe and let the water go through the G-tube by gravity (method used to deliver formulas). ULP-G connected R2's enteral feeding to G-tube	01950		

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01950	Continued From page 33 via kangaroo pump at a rate of 100 ml/hr. R2 was admitted to the licensee on April 15, 2023. R2's Service Plan (Wavier) - Addendum to Contract dated December 27, 2023, indicated R2 received assistance with medication administration and enteral (intake of food via the gastrointestinal tract) gastrostomy tube (surgical placed device to give direct access to the stomach) feeding. R2's Individualized Medication Management Plan (IMMP) dated November 30, 2025, lacked any instructions regarding R2's enteral feeding, water flushes through G-tube, or oral dietary needs. R2's Individualized Treatment and Therapy Plan - as of Date (ITTP) dated January 22, 2026, lacked any instructions regarding R2's enteral feeding, water flushes through G-tube, or oral dietary needs. R2's Master Care Plan dated November 30, 2025, indicated the following: - Diet: soft; - Diet Texture: mechanical altered (minced and moist); - Diet Liquids: honey thick (moderately thick) - Activities of daily living (ADL) Needs - Eating Needs - Feeding: required use of a tube or parenteral or intravenous instructions to be fed. Note: follow instructions, keep resident head of bed raised 60 degrees all times. Needs to be supervised while eating and/or drinking due to difficulty swallowing. Note: the resident will keep the head of bed 60-degree angle all times. Follow container directions for nectar thick liquids and feed resident pureed diet.	01950		

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01950	Continued From page 34 - ADL Needs - Nutritional / Hydration Status - Nutritional status: note: resident has tube feeding and eats meals. The resident appears thin but gets most calories from tube feeding due to the resident refusing to eat meals. Hydration status: note: resident has dry mucous membranes and skin. Staff should encourage nectar thick liquids throughout the day. Risk for dehydration: note: the resident is at risk for dehydration due to purred (sp) (pureed) liquids which resident does not like. Staff will follow hydration orders. Current fluid intake pattern: note: staff should offer fluids (water, juice, etc) every two hours and continue to flush resident as ordered. ENTERAL FEEDING R2's order dated April 9, 2025, indicated R2 was to receive Promote 1800 calories per day via pump at a rate of 1496 ml/hr. The order was obtained from Corner Home Medical on January 22, 2026 (survey exit date). The order had a different enteral formula than the formula being administered by staff, which did not indicate if a comparable formula could be used in place of Promote; or if the formula should be with or without fiber. Also, the rate for the enteral feeding to be administered through the pump was different than the rate observed to be given by the surveyor; and the order did not clarify the route of administration or duration of the enteral feeding or if the feeding was to be administered overnight for increased oral intake. R2's Treatment Recap Summary - Monthly (TAR) dated January 2026, indicated Tube feeding at 7:00 a.m. and 5:00 p.m. The TAR did not indicate other instructions for R2's tube feeding, water flushes through G-tube, or dietary needs. On January 21, 2026, at 1:56 p.m., RN-F stated	01950		

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01950	Continued From page 35 staff were to stop R2's enteral feeding at 7:00 a.m. (one hour before their 8:00 a.m. meds) and then reconnect the enteral feeding at noon. On January 21, 2026, at 2:13 p.m., ULP-A stated R2's enteral feeding would be disconnected at 7:00 a.m., reconnected at 12:00 p.m., disconnected at 7:00 p.m., and then reconnected at 9:00 p.m. On January 21, 2026, at 2:44 p.m., the surveyor went into R2's room with ULP-A to get a picture of R2's enteral formula. Upon entering R2's room, the surveyor observed R2's enteral feeding was connected but the pump was stopped and did not have any active alarms sounding. ULP-A stated that sometimes the pump just stops so we just start again. It is not clear how long the pump at been stopped or if the nurse is notified when this occurs. On January 21, 2026, at 2:13 p.m., ULP-A confirmed they could not view instructions in R2's record for the amount or rate of R2's enteral feedings. ULP-A stated they just followed the written instructions on R2's medication administration record (MAR) and treatment administration record (TAR); and then showed the surveyor the written instructions they were able to view in R2's record for enteral feeding which included the following: tube (enteral) feeding at 7:00 a.m., stop tube feeding after 14 hours, notify RN if R2 is not eating orally. ULP-A stated the licensee did not check or document the mark on the G-tube for placement prior to administering enteral feeding; and if they had any concerns with R2's G-tube not looking normal, then they would let the nurse know. R2's record lacked specific instructions for the	01950		

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01950	Continued From page 36 proper methods to administer R2's enteral feeding, including times to stop and start the enteral feedings. On January 22, 2026, at 11:41 a.m., clinical nurse supervisor (CNS)-D stated they considered enteral feeding to be a treatment. G-TUBE WATER FLUSHES R2's record lacked orders for flushing R2's G-tube with purified water, but the surveyor observed staff performing the treatment of administered water through G-tube. The surveyor was not clear if the administration of water through R2's G-tube needed to be flushed or if the administration of water could be delivered using the method of gravity which is generally used to administer enteral formula. R2's Med Admin Summary - Actual - Month (MAR) dated January 2026, indicated R2 was to receive purified water (daily) flush of 240 ml twice daily at 8:00 a.m. and 8:00 p.m. The instructions did not include the route for the water flush; and if the water could be administered by method of gravity as observed by the surveyor. Also, the MAR did not indicate R2's G-tube was to be flushed with purified water at noon. On January 21, 2026, at 2:13 p.m., ULP-A confirmed with the surveyor the following schedule they performed for R2's G-tube water flushes as follows: - 7:00 a.m. - disconnect the enteral feeding and flush with half of a 16 oz bottle of water (approximately 236 ml); - 8:00 a.m. - administer R2's medications through the G-tube and flush with another one and a half 16 oz bottles of water (approximately 709 ml); - noon - flush with another 16 oz bottle of water	01950		

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01950	Continued From page 37 (473 ml) and reconnect the enteral feeding; - 7:00 p.m., disconnect the enteral feeding and flush with half of a 16 oz bottle of water (approximately 236ml); - 8:00 p.m., administer R2's medications through the G-tube and flush with another one and a half 16 oz bottles of water (approximately 709 ml); and - 9:00 p.m., flush again with water, ULP-A stated they thought it was a 16 oz bottle of water (473 ml) but was not sure. Then ULP-A would reconnect R2's enteral feeding, turn on the pump, and make sure the pump read 100 ml per hour. On January 21, 2026, at 3:10 p.m., ULP-E stated they would flush R2's G-tube with purified water between 7:00 p.m. and 9:00 p.m. with 473 ml, then stated maybe less like 414 ml or 369 ml, with the administration of R2's medications. On January 22, 2026, at 12:21 p.m., CNS-D confirmed staff should administer 240 ml two times per day. CNS-D stated they were not aware that staff flushed R2's G-tube three times per day and with more water than instructed. CNS-D stated additional training would be needed; and more specific instructions should be written for the staff. R2's record lacked specific instructions for the proper methods to administer R2's G-tube water flushes. ORAL DIETARY NEEDS R2's record lacked orders for R2's oral dietary needs that included mechanical diet (modified diet designed for individuals who have difficulty chewing or swallowing to help to prevent choking and aspiration) for a resident that also received enteral nutritional support through a G-tube.	01950		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 38 On January 21, 2026, at 1:39 p.m., LALD-C stated R2 no longer got food orally as R2 had always refused any food offered. On January 21, 2026, at 1:56 p.m., RN-F stated at one point in time, R2 had been trying to eat food orally but had to revert to just getting their nutrition from the enteral feedings. RN-F confirmed R2 had been nothing per oral (NPO) since 2024. On January 21, 2026, at 2:13 p.m., ULP-A stated R2 had not had any food or liquid per oral for about the last two years. ULP-A stated they try to give R2 foods like Cream of Wheat, yogurt, or mashed potatoes but R2 does not take this. ULP-A stated they needed to continue to offer R2 food as it was still in the system directing them to do so. ULP-A showed the surveyor the instructions they viewed in R2's record as follows: - record - intake of fluids, a.m., document fluid intake: nectar thick liquids (type of mechanical diet), offer drinks often; and - record - meal percentage, a.m., document percent of meal eaten by mouth after staff feeds resident. On January 22, 2026, at 12:28 p.m., CNS-D stated the plan was to offer R2 food and nectar thickened liquids (type of modified diet). The licensee's Treatment and Therapy Management Services policy dated November 1, 2025, indicated treatments shall be administered by agency staff only as ordered by the physician or designated prescriber. Also, if the treatment were to be provided by unlicensed personnel, the treatment would be documented in the care plan with delegation of the task documented by the	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39424	A. BUILDING: _____ B. WING _____	01/22/2026

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01950	Continued From page 39 Registered Nurse. The policy referenced 144A Statute and not 144G Statute. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronic treatment orders were maintained for one of one resident (R2) who had treatments related to gastrostomy tube (G-tube) that included enteral feeding, oral diet needs, and G-tube flushes. 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).	01970		

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01970	Continued From page 40 The findings include: On January 21, 2026, at 12:07 p.m., the surveyor observed unlicensed personnel (ULP)-A get a new 1,200 milliliter (ml) enteral feeding pump bag set with tubing and fill the bag with Jevity 1.2 Cal (type of enteral formula). ULP-A stated they were told to put the whole bottle in the bag and then prime the tubing. The surveyor observed kangaroo pump was set at a rate of 100 ml per (/) hour (hr). ULP-A disconnected the enteral feeding, connected a 60 ml syringe and poured purified water into the syringe and let the water go through the enteral tube by gravity (method used to deliver formulas). ULP-A stated they were not flushing (method used to clean the feeding tube to prevent clogging and maintain hygiene after each feeding, medication or as directed by healthcare provider) R2's G-tube, just giving water to hydrate. ULP-A stated they give R2 one 16 oz (473 ml) bottled water every day at noon. ULP-A connected R2's enteral feeding to R2's G-tube via kangaroo pump at a rate of 100 ml/hr after giving water. On January 22, 2026, at 12:01 p.m., upon entry to R2's room, the surveyor observed R2's enteral feeding was disconnected from R2's G-tube. The enteral tubing had a full bag of formula already prepared and was actively dripping onto the floor from the end of the tubing. ULP-G connected a 60 ml syringe and poured half of a 16 oz bottle of purified water (approximately 236 ml) into the syringe and let the water go through the G-tube by gravity (method used to deliver formulas). ULP-G connected R2's enteral feeding to G-tube via kangaroo pump at a rate of 100 ml/hr. R2 was admitted to the licensee on April 15,	01970		

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01970	Continued From page 41 2023. R2's Service Plan (Wavier) - Addendum to Contract dated December 27, 2023, indicated R2 received assistance with medication administration and enteral (intake of food via the gastrointestinal tract) gastrostomy tube (surgical placed device to give direct access to the stomach) feeding. R2's Med Admin Summary - Actual - Month (MAR) dated January 2026, indicated R2 was to receive purified water (daily) flush of 240 ml twice daily at 8:00 a.m. and 8:00 p.m. The MAR did not indicate any other instructions on water flushes. R2's Treatment Recap Summary - Monthly (TAR) dated January 2026, indicated Tube feeding at 7:00 a.m. and 5:00 p.m. The TAR did not indicate other instructions for R2's tube feeding, water flushes through G-tube, or dietary needs. R2's Individualized Medication Management Plan (IMMP) dated November 30, 2025, lacked any instructions regarding R2's enteral feeding, water flushes through G-tube without medication administration, or dietary needs. R2's Individualized Treatment and Therapy Plan - as of Date (ITTP) dated January 22, 2026, lacked any instructions regarding R2's enteral feeding, water flushes through G-tube, or dietary needs. R2's Instructions dated August 1, 2023, indicated new tube feeding (TF) regimen to promote increased oral intake. R2 was to receive Nocturnal feeds: 14 hours (hrs), run Promote with Fiber (type of enteral formula) for 14 hrs at 100 ml/hr. The instructions indicated this would provide R2 with 1400 kilocalories (Kcal), 88 gram	01970		

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01970	Continued From page 42 (g) protein, and 1163 ml water. Also, handwritten instructions indicated extra calorie by mouth: at least 565 calories. The instructions were identified as R2's order but were not authenticated by an acceptable provider; and had a different type of enteral formula than what the surveyor had observed to be given to R2. R2's order dated August 1, 2023, indicated R2 was to receive Promote with fiber or comparable formula at rate of 100 ml/hr for 14 hrs overnight to promote increased oral intake. The order indicated tube feeding with food and free water. The order was obtained from Corner Home Medical on January 22, 2026 (survey exit date). The order did not include the route for the enteral feeding, the number of extra calories needed by mouth as indicated on the resident instructions dated August 1, 2023, and did not indicate the amount of free water needed or the method of administering the free water. R2's Provider Contact dated January 16, 2024, was identified as R2's orders by CNS-D, indicated handwritten instructions from R2's provider as follows: R2 was to keep urology appointment for evaluation on catheter; and a Cologuard (colon cancer) screening was sent. The Provider Contact had typed information from the licensee to indicate R2's diet was soft (type of mechanical diet for food, not liquids). The form had a printed attached active medication list with treatments identified by licensee as follows: Flush gastrostomy tube with 240 ml of purified water twice daily for hydration; run Promote with Fiber for 14 hr/day at a rate of 100 ml/hr; and resident is to consume at least 565 calories orally daily. The attached active medication list with treatments was not authenticated by the provider; and the provider did not acknowledge to continue	01970		

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01970	Continued From page 43 with all active medications and treatments as identified on the attached medication list created by the licensee. R2's order dated April 9, 2025, indicated R2 was to receive Promote 1800 calories per day via pump at a rate of 1496 ml/hr. The order was obtained from Corner Home Medical on January 22, 2026 (survey exit date). The order had a different enteral formula than the formula being administered by staff, which did not indicate if a comparable formula could be used in place of Promote; or if the formula should be with or without fiber. Also, the rate for the enteral feeding to be administered through the pump was different than the rate observed to be given by the surveyor; and the order did not clarify the route of administration or duration of the enteral feeding or if the feeding was to be administered overnight for increased oral intake. R2's record lacked orders for flushing R2's G-tube with purified water; and lacked orders for R2's oral diet needs with G-tube and/or mechanical diet (modified diet designed for individuals who have difficulty chewing or swallowing helping to prevent choking and aspiration) needs. On January 21, 2026, at 1:56 p.m., registered nurse (RN)-F stated R2's orders had not changed since they moved into the facility. RN-F stated they did get "side orders" for R2's G-tube. RN-F stated at one point in time, R2 had been trying to eat food orally but had to revert back to just getting their nutrition from the enteral feedings. RN-F confirmed R2 had been nothing per oral (NPO) since 2024. On January 21, 2026, at 2:13 p.m., ULP-A stated	01970		

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01970	Continued From page 44 R2 had not had any food or liquid per oral for about the last two years. ULP-A stated they try to give R2 foods like Cream of Wheat, yogurt, or mashed potatoes but R2 does not take this. ULP-A stated they needed to continue to offer R2 food as it was still in the system directing them to do so. On January 22, 2026, at 11:08 a.m., clinical nurse supervisor (CNS)-C stated they had contacted R2's provider (after the initiation of survey) who oversaw R2's enteral G-tube feeding but found the provider had retired. CNS-D stated R2 had established care with another doctor in November, which at that time they needed to get new orders for the pharmacy as well. CNS-D stated they were still waiting for a fax on the current orders from the doctor's office. On January 22, 2026, at 11:41 a.m., CNS-D stated they considered enteral feeding to be a treatment. On January 22, 2026, at 12:21 p.m., CNS-D showed the surveyor previous orders for R2 dated January 16, 2024 (R2's Provider Contact). CNS-D confirmed staff should administer 240 ml /day of water two times per day. CNS-D stated they were not aware that staff administered water three times per day and could see additional training was needed along with more specific instructions. On January 22, 2026, at 12:28 p.m., CNS-D stated the plan is to offer R2 food and nectar thickened liquids (type of modified diet). CNS-D confirmed the licensee did not have the original orders for R2's enteral feeding, water flushes or R2's oral dietary needs, just the form that was sent to the MD office on January 16, 2024, for	01970		

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01970	Continued From page 45 signature. CNS-D and RN-F acknowledged the concerns with not having current and accurate orders for R2's enteral feeding, water flushes or oral diet needs. The licensee's Treatment and Therapy Management Services policy dated November 1, 2025, indicated orders must be obtained for medications, treatments, or therapies that would require orders from an authorized provider; only be administered by staff as ordered by the physician or designated prescriber; and orders would be reviewed at least every three months (90 days) during the assessment visits; orders would be updated whenever there was a change in medications or treatments. The policy referenced 144A Statute and not 144G Statute. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display	03090		

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03090	Continued From page 46 statutory language to disclose electronic monitoring activity. This had the potential to affect the current residents, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: On January 20, 2026, at 10:00 a.m., upon the surveyor's arrival to the facility, the surveyor did not observe the required notice displaying the statutory language to disclose electronic monitoring activity at the front door or in the entry of the facility. On January 20, 2026, at 11:19 a.m., during a facility tour, the surveyor observed a sign posted in the common kitchen, on the door leading to the garage, that read, "Notice, video surveillance, may be in use for the safety of our clients." The sign displayed did not have the statutory language to disclose electronic monitoring activity; and was not posted at the main entry way of the facility. On January 20, 2026, at 11:46 a.m., licensed assisted living director (LALD)-C stated the facility did not have any other postings of the required statutory language to disclose electronic monitoring activity. LALD-C stated they thought the sign posted was the required statutory language. LALD-C stated the truth was that the Minnesota Department of Health had changed	03090		

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03090	Continued From page 47 the statutory language; and they hoped the language had not changed again. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

Hopeville Homes
4801 78th Lane North
Brook Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39424

Risk:
License:
Expires on:
CFPM: DEAREST BADIO
CFPM #: 122198; Exp: 01/21/2027

Inspection Info

Report Number: F1062261010
Inspection Type: Full - Single
Date: 1/20/2026 Time: 10:30 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION COMPLETED WITH Rhawnie Quinehan HRD.

NO VIOLATIONS OBSERVED DURING INSPECTION.

DRYWALL, TILE FLOOR, LAMINATE COUNTERS

DISCUSSED DISHWASHER SANITIZER TESTING, ILLNESS RECORDING AND REPORTING, AND THE PROHIBITION OF KEEPING PREPARED FOOD FOR LONGER THAN 24 HOURS.

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 F1062261010 from 1/20/2026

CARLOS SMITH
OPERATOR

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

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

Temperature Observations/Recordings

Establishment Info

Hopeville Homes
Brook Park
County/Group: Hennepin County

Inspection Info

Report Number: F1062261010
Inspection Type: Full
Date: 1/20/2026
Time: 10:30 AM

Equipment Temperature: Product/Item/Unit: REFRIGERATOR**; Temperature Process:** Cold-Holding
Location: KITCHEN at 40 Degrees F.
Comment:
Violation Issued?: No

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

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

Sanitizer Observations/Recordings

Establishment Info

Hopeville Homes
Brook Park
County/Group: Hennepin County

Inspection Info

Report Number: F1062261010
Inspection Type: Full
Date: 1/20/2026
Time: 10:30 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 162 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39424016	**Date:** 1/21/2026
Facility Name: Hopeville Homes	
Facility Address: 4801 78th lane N, Brooklyn Park MN 55443	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms 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 facility was equipped with hard wired smoke alarms that were interconnected, and battery operated smoke alarms that are interconnected in all required locations. Licensed assisted living director (LALD)-C stated that the two systems are not interconnected with each other and was not sure why their maintenance person had installed a second interconnected smoke alarm system.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.

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

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

   Comments: LALD-C stated that resident training on the FSEP is verbal and provided no training documentation to review.