Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

April 28, 2026

Licensee
Golden Nest LLC
1918 19th Avenue Northeast
Minneapolis, MN 55418

RE: License Number 421127
Health Facility Identification Number (HFID) 27473
Project Numbers SL27473017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on March 25, 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 Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

Golden Nest was issued a conditional license on October 3, 2025, pursuant to the Notice of Stay of Immediate Temporary Suspension and Revocation executed on that date. Based on the findings of the follow-up survey conducted on March 25, 2026, as well as the follow-up survey conducted on November 13, 2025, MDH concludes Golden Nest is in substantial compliance. The conditions on the license are removed effective April 28, 2026. Additionally, per the October 3, 2025, Stay, the Notice and Order of Immediate Temporary Suspension and Notice of Revocation, dated August 21, 2025, is rescinded.

State law requires the facility must take action to correct any outstanding violations 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.

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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: SL27473017-0 On March 23, 2026, through March 25, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider and the following correction orders are issued. At the time of the survey, there were 19 residents; 19 receiving services under the conditional 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.	
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 660	Continued From page 1 (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 a chest x-ray (CXR) and medical evaluation was completed within 90 days of a documented positive TB test for one of two employees (unlicensed personnel (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 potential to affect a large portion or all of the residents). The findings include:	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 660	Continued From page 2 The licensee's Facility TB Risk Assessment dated October 15, 2025, indicated the facility was at a low risk level for TB transmission. ULP-B was hired on August 11, 2023, to provide direct care to residents. ULP-B's employee record included a CXR result from dated July 11, 2023, and indicated ULP-B did not have active signs of TB. ULP-B's employee record included an ArchPoint Labs QuantiFERON TB test result dated September 25, 2025, and indicated ULP-B tested positive for TB. ULP-B's employee record lacked a CXR and medical evaluation completed within 90 days after a positive TB test result to rule out active infectious TB disease. On March 24, 2026, at 10:25 a.m., licensed assisted living director (LALD)-D stated they were unaware a CXR needed to be completed within 90 days after a positive TB test in order for the CXR to be valid. ULP-B stated they did not get a CXR completed after their September 25, 2025, positive TB test. ULP-B stated they had the vaccine and the only CXR they had completed was from July 11, 2023, which did not have a positive test result to go with it. The Minnesota Department of Health TB Frequently Asked Questions (FAQ) dated March 9, 2026, indicated if the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 660	Continued From page 3 CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated: employees with written documentation of a previous positive tuburculin skin test (TST) or blood test do not need a repeat TST or blood test: -Assess for current TB symptoms -If they provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. -If they do not have the written documentation from above, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease before having direct patient contact. -Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. -After the baseline chest x-ray is performed and the result is documented, repeat x-rays are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 4 (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 plan (EPP) with all the required content for staff, residents, and visitors to view. 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).	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 5 The findings include: On March 24, 2026, at 9:30 a.m., the surveyor reviewed the licensee's Emergency Preparedness and Fire Safety and Evacuation Manual, last reviewed by the licensee on April 30, 2025. The EPP lacked the following required content: -include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; -primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; -includes policies/procedures (P/P) for at minimum food, water, and pharmaceutical supplies; -qualified person who is authorized in writing to act in the absence of the administrator; -communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; and -P/P must address: use of volunteers, including the process/role for integration. On March 24, 2026, at 10:25 a.m., licensed assisted living director (LALD)-D stated they did not know they needed to have an authorized person to act in their absence formally addressed in the EPP. LALD-D stated they thought they addressed state, federal, tribal and regional contacts communication info in their communication plan but were unable to find it when the surveyor requested they find it in the EPP. LALD-D was unsure of the quantity of food, water, and medical supplies needed to sustain	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 6 their residents in a disaster situation and stated it was not in the EPP binder. LALD-D stated they did not utilize volunteers, so they did not address them in the EPP. LALD-D stated they did not have contact information for some of the requirements but would get it added to the EPP. The licensee's Emergency Preparedness policy dated October 13, 2025, indicated, "[Licensee] will 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. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, 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.	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 775	Continued From page 7 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 8 (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 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:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 9 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 810		
0 830 SS=F	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 follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking. 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	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 830	Continued From page 10 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's facility was a three-level apartment building converted into an assisted living facility with each resident having their own room/apartment. R5 R5 was admitted to the licensee on June 12, 2023, living in room A-3. R5's Service Plan dated November 26, 2025, indicated R5 was, "At risk for unsafe smoking behaviors. When you observe a smoke smell in the hallway, please bring to [R5's] attention. [R5] does not like to be asked about smoking in the building. Remain calm, validate resident feeling annoyed. Express concern for safety." R5's record lacked a smoking safety assessment with safety interventions. R6 R6 was admitted to the licensee on January 9, 2012. R6's Service Plan dated October 22, 2025, indicated R6 received services for medication management. The service plan did not address R6's smoking habits. R6's record lacked a smoking safety assessment with safety interventions. On March 23, 2026, at 11:22 a.m., the nurse surveyor was in the second floor hallway and noticed the heavy smell of smoke outside of room	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 830	Continued From page 11 A-3, but was unable to access the room. On March 23, 2026, at 12:05 p.m., the environmental engineer (EE) surveyor stated they found evidence of smoking in R5's room A-3 and showed a photograph they had taken with a coffee cup and small paper cup filled with water and cigarette ash in the water. The nurse surveyor observed A-3's room and observed the same cups filled with water and cigarette ash. On March 23, 2026, at 12:49 p.m., licensed assisted living director (LALD)-D stated they were unsure if a smoking safety assessment had been completed for R5. LALD-D stated they were unsure how to address R5's smoking and were trying to figure out ideas; R5 would not listen to them. LALD-D stated R5's smoking was primarily an issue during the winter with the cold weather. LALD-D stated if they catch R5 smoking they tell them to stop. On March 24, 2026, at 1:17 p.m., LALD-D stated they only had two smokers in the facility. LALD-D stated they had issues with R5's smoking indoors but R6 always smoked outdoors. LALD-D stated neither R5 nor R6 had a smoking assessment. On March 25, 2026, at 9:18 a.m., the surveyor observed R5's room which had a moderate level of cigarette smoke smell; the two cups of water and ash were no longer in the room. On March 25, 2026, at 9:25 a.m., activities personnel/unlicensed personnel (A/ULP)-G stated R5 did smoke inside but were not supposed to. A/ULP-G stated, if they catch R5 smoking, they have been instructed to remind her they need to smoke outside. A/ULP-G stated R5 was ambulatory and was able to get outside	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 830	Continued From page 12 independently. A/ULP-G stated typically the problem with R5 smoking indoors was during the winter because it was cold outside. A/ULP-G stated R6 smoked but always smoked outdoors. On March 25, 2026, at 9:30 a.m., ULP-H stated R5 did smoke in the house, they can smell cigarette smoke as well. The surveyor inquired what the nurse instructed ULP-H to do if they caught R5 smoking indoors; ULP-H stated they did not know what to do and said the surveyor would need to ask the nurse. On March 25, 2026, at 9:30 a.m., LALD-D stated a smoking assessment had still had not been completed for R5 or R6. LALD-D stated the consultant registered nurse acting as clinical nurse supervisor (CNS)-F would be coming into the facility to do them today, March 25, 2026. LALD-D stated they did not have any smoking interventions in place other than to remind R5 not to smoke indoors. LALD-D stated CNS-A was supposed to handle smoking assessments, but they quit working for the licensee five days prior. On March 25, 2026, at 10:43 a.m., the surveyor received an email from CNS-F which indicated, "As far as [R5] and smoking goes, yes, we learned that this was an issue when it was very cold outside, and smoking was addressed at that time with the resident by either [CNS-A] or [LALD-D]. Additionally, [LALD] was looking into adding an indoor smoking room, and I believe it was decided that it was not going to happen, but I apologize, I do not remember the reason why. I have not seen smoking assessments as an option in the EHR [charting software] Residex [charting software] has a robust smoking assessment, but I do not think resident has one, and when I audited the clinical records, I do not	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 830	Continued From page 13 recall seeing written smoking assessments. I would be happy to complete smoking assessments for the residents who smoke when I am on site this afternoon. The soonest I would be able to talk on the phone would be when I finish with my current client at 1pm, and am driving to [licensee]. I completely agree that if [R5] is still smoking inside, [R5] needs interventions in place today." On March 25, 2026, at 2:21 p.m., CNS-F stated they would complete smoking safety assessments today and implement interventions. CNS-F stated they were working in a consulting capacity and CNS-A had been handling assessments and interventions, but they quit working for the licensee on March 20, 2026. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated, "The RN will provide the admission visit, conduct and document** a comprehensive assessment*** and prepare a care plan based on the comprehensive evaluation." The licensee's Smoking policy dated October 13, 2025, indicated: "1. If smoking is allowed indoors, it is limited to a designated separate, enclosed room and: -Smoking indoors is allowed only for residents of a facility -Facility staff, volunteers and guests are banned from smoking indoors -No smoking is allowed in the rest of the facility -A sign will be posted at each entrance to the facility that states: "Smoking is prohibited, except in designated areas" -A sign is posted at the entrance to the designated smoking room stating, "Smoking	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
0 830	Continued From page 14 Permitted" or displaying the international smoking-permitted symbol." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
01620	Continued From page 15 Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a smoking safety assessment for two of two residents (R5, R6). 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:	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
01620	Continued From page 16 R5 R5 was admitted to the licensee on June 12, 2023, living in room A-3. R5's Service Plan dated November 26, 2025, indicated R5 was, "At risk for unsafe smoking behaviors. When you observe a smoke smell in the hallway, please bring to [R5's] attention. [R5] does not like to be asked about smoking in the building. Remain calm, validate resident feeling annoyed. Express concern for safety." R5's record lacked a smoking safety assessment. R6 R6 was admitted to the licensee on January 9, 2012. R6's Service Plan dated October 22, 2025, indicated R6 received services for medication management. The service plan did not address R6's smoking habits. R6's record lacked a smoking safety assessment. On March 23, 2026, at 11:22 a.m., the nurse surveyor was in the second floor hallway and noticed the heavy smell of smoke outside of room A-3, but was unable to access the room. On March 23, 2026, at 12:05 p.m., the environmental engineer (EE) surveyor stated they found evidence of smoking in R5's room A-3 and showed a photograph they had taken with a coffee cup and small paper cup filled with water and cigarette ash in the water. The nurse surveyor observed A-3's room and observed the same cups filled with water and cigarette ash.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
01620	Continued From page 17 On March 23, 2026, at 12:49 p.m., licensed assisted living director (LALD)-D stated they were unsure if a smoking safety assessment had been completed for R5. LALD-D stated they were unsure how to address R5's smoking and were trying to figure out ideas; R5 would not listen to them. LALD-D stated R5's smoking was primarily an issue during the winter with the cold weather. LALD-D stated if they catch R5 smoking they tell R5 to stop. On March 24, 2026, at 1:17 p.m., LALD-D stated they only had two smokers in the facility. LALD-D stated they had issues with R5's smoking indoors but R6 always smoked outdoors. LALD-D stated neither R5 nor R6 had a smoking assessment. On March 25, 2026, at 9:30 a.m., LALD-D stated a smoking assessment had still had not been completed for R5 or R6. LALD-D stated the consultant registered nurse acting as clinical nurse supervisor (CNS)-F would be coming into the facility to do them today, March 25, 2026. LALD-D stated they did not have any smoking interventions in place other than to remind R5 not to smoke indoors. LALD-D stated CNS-A was supposed to handle smoking assessments, but they quit working for the licensee five days prior. On March 25, 2026, at 10:43 a.m., the surveyor received an email from CNS-F which indicated, "As far as [R5] and smoking goes, yes, we learned that this was an issue when it was very cold outside, and smoking was addressed at that time with the resident by either [CNS-A] or [LALD-D]. Additionally, [LALD] was looking into adding an indoor smoking room, and I believe it was decided that it was not going to happen, but I apologize, I do not remember the reason why. I have not seen smoking assessments as an	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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
01620	Continued From page 18 option in the EHR [charting software] (Residex) [charting software] has a robust smoking assessment, but I do not think Resident has one, and when I audited the clinical records, I do not recall seeing written smoking assessments. I would be happy to complete smoking assessments for the residents who smoke when I am on site this afternoon. The soonest I would be able to talk on the phone would be when I finish with my current client at 1pm, and am driving to [licensee]. I completely agree that if [R5] is still smoking inside, [R5] needs interventions in place today." On March 25, 2026, at 2:21 p.m., CNS-F stated they would complete smoking safety assessments today and implement interventions. CNS-F stated they were working in a consulting capacity and CNS-A had been handling assessments and interventions, but they quit working for the licensee on March 20, 2026. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated, "The RN will provide the admission visit, conduct and document** a comprehensive assessment*** and prepare a care plan based on the comprehensive evaluation." Minnesota Rules Chapter 4659.0150 dated August 11, 2021, indicated the uniform assessment tool must include risk indicators such as smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27473	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL27473017-0	**Date:** 3/23/2026
Facility Name: Golden Nest LLC	
Facility Address: 1918 19th Ave N, Minneapolis MN 55418	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: The fire door on the third floor between the stairwell and the common hallway would not latch. Licensed assisted living director (LALD)-D stated that they were not aware of the issue and would have it corrected immediately.

3. Exit signs shall be illuminated at all times. To ensure continued illumination for a duration of not less than 90 minutes in case of primary power loss, the sign illumination means shall be connected to an emergency power system provided from storage batteries, unit equipment or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1013.6.3]

   Comments: The exit sign in the second floor common hallway leading into the south stairwell was not lit at the time of survey. LALD-D stated that their contractor had been through previously to repair the exit lights, and that they would have them come back to repair the exit light.

4. Automatic fire extinguishing systems for commercial cooking shall be serviced at least once every six months. [Minn. Stat. 144G.45 subd. 2; MSFC 904.12.5.2]

   Comments: The hood suppression system in the commercial kitchen had a service tag that indicated the hood suppression system was last serviced August 2021.

5. Interior wall and ceiling finish shall have a flame spread index not greater than a class C rating. [Minn. Stat. 144G.45 subd. 2; MSFC 803.3]

Comments: Privacy curtains of an unknown fabric were installed in resident rooms M-2, M-3, and M-4. LALD-D stated that they were instructed to install the curtains for privacy after the last survey. LALD-D was unable to provide any information on where the curtains were purchased, what material the curtains were made of, or if they had an appropriate flame spread index.

6. Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or a minimum of 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 315.3.1]

   Comments: Solid floor to ceiling privacy curtains were installed in resident rooms M-2, M-3, and M-4. LALD-D stated that they were instructed to install the curtains for privacy after the last survey. The curtains were suspended approximately 3 inches from the ceiling on a sliding track creating a sprinkler obstruction in the resident rooms.

☒ **TAG IDENTIFICATION: 0810**

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

---

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

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

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

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