



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

September 4, 2026

Licensee

Bridge Health Care Services LLC

1701 Irving Lane North

Brooklyn Center, MN 55430

RE: Denial of License Number 418181
Health Facility Identification Number (HFID) 41108
Initial survey; Project Number(s) SL41108015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on July 29, 2026, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

INELIGIBLE LICENSURE TIMELINE

Pursuant to Minn. Stat. § 144G.16, subd. 3 (c), the owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one (1) year following the facility's closure date.

STATE CORRECTION ORDERS

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

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Casey DeVries, via email at: Casey.DeVries@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care **no later than September 7, 2026**.

Pursuant to Minn. Stat. § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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.

If you have any additional questions, please do not hesitate to contact Casey DeVries, Supervisor, at Casey.DeVries@state.mn.us. Casey DeVries can also be reached by office phone at 651-201-5917.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE HEALTH CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 IRVING LANE NORTH BROOKLYN CENTER, MN 55430			
(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: SL41108015-0 On July 27, 2026, through July 29, 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 two resident(s); two receiving services under the Provisional 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.		
0 180 SS=F	144G.16 Subd. 2 Initial survey (a) During the provisional license period, the commissioner shall survey the provisional	0 180			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 180	Continued From page 1 licensee after the commissioner is notified or has evidence that the provisional licensee is providing assisted living services to at least one resident. (b) Within two days of beginning to provide assisted living services, the provisional licensee must provide notice to the commissioner that it is providing assisted living services by sending an e-mail to the e-mail address provided by the commissioner. (c) If the provisional licensee does not provide services during the provisional license period, the provisional license shall expire at the end of the period and the applicant must reapply. (d) If the provisional licensee notifies the commissioner that the licensee is providing assisted living services within 45 calendar days prior to expiration of the provisional license, the commissioner may extend the provisional license for up to 60 calendar days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Minnesota Department of Health (MDH) within two days of first providing services. 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).	0 180			

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0 180	Continued From page 2 The findings include: The licensee was issued their Provisional Assisted Living license effective October 10, 2024. R1 was admitted and began receiving assisted living services on January 17, 2025. The licensee submitted a Notice of Providing Assisted Living Services form to MDH. The form indicated they began providing services for R1 on January 17, 2025. Owner/unlicensed personnel (O/ULP)-E signed the form on January 17, 2025. On January 27, 2025, at 3:28 p.m., the licensee sent an email to notify MDH they started providing assisted living services. The email was sent to MDH 10 days after admitting their first resident, R1. The licensee failed to provide notice to MDH within two (2) days of the licensee first providing assisted living services. On July 27, 2026, at 11:05 a.m., licensed assisted living director (LALD)-D provided the above-mentioned email and stated the notice was sent in late. LALD-D stated neither they nor clinical nurse supervisor (CNS)-A were employed by the licensee at the time it was sent in. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 180			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

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

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0 480	Continued From page 4 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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, Food and Beverage Establishment Inspection Report (FBEIR) dated July 28, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on July 28, 2026.	0 480			

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0 480	Continued From page 5	0 480			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health	0 500			

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0 500	Continued From page 6 professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. 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: On July 29, 2026, at 1:03 p.m., the surveyor requested the licensee's policies via email as they were not able to do so while the surveyor was onsite. The following policies were requested: "-required resident records content -TB [tuberculosis] testing and education; -required employee records; -contract contents; -designated representative; -required annual training; -dementia training; -medication assessment;	0 500			

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0 500	Continued From page 7 -medication orders, prescriptions; -medication administration and documentation; -medication storage; -medication labeling; and -policy for whether or not they allow residents to keep their own OTC and if they need an RX." The licensee failed to provide the following policies and procedures related to current assisted living requirements: -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; -medication and treatment management; and -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
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 information: (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;	0 650			

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0 650	Continued From page 8 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document their employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for three of three employees who were employed more than 12 months (unlicensed personnel (ULP)-B, licensed assisted living director (LALD)-D, owner/ULP (O/ULP)-E). Further, the licensee failed to document their employees received two hours of annual dementia training and one hour of annual deescalation training for three of three employees (ULP-B, LALD-D, O/ULP-E). 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:	0 650			

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0 650	Continued From page 9 ULP-B ULP-B was hired on January 17, 2025, to provide direct care to residents. ULP-B's Educare (online training platform) transcript lacked eight hours of required annual training on the following topics: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; - principles of person-centered planning/service delivery; and - hearing loss training (optional). ULP-B's Educare transcript lacked the following required annual dementia care training: - two hours of dementia training; and - one hour of deescalation training. On July 27, 2026, at 12:20 p.m., the surveyor observed ULP-B assisting R2 with mobility in their wheelchair (w/c). LALD-D LALD-D was hired on January 29, 2025, to provide facility oversight and direct cares to residents. LALD-D's Educare transcript lacked eight hours of required annual training on the following topics: - reporting maltreatment of vulnerable adults or minors;	0 650			

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0 650	Continued From page 10 - assisted living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; - principles of person-centered planning/service delivery; and - hearing loss training (optional). LALD-D's Educare transcript lacked the following required annual dementia care training: - two hours of dementia training; and - one hour of deescalation training. On July 26-28, 2026, the surveyor observed LALD-D performing oversight duties and assist the surveyor with the survey process. O/ULP-E O/ULP-E was hired on January 17, 2025, and provided ownership duties and direct care to residents. O/ULP-E's Educare transcript lacked eight hours of required annual training on the following topics: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; - principles of person-centered planning/service delivery; and	0 650			

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0 650	Continued From page 11 - hearing loss training (optional). O/ULP-E's Educare transcript lacked the following required annual dementia care training: - two hours of dementia training; and - one hour of deescalation training. On July 29, 2026, at 7:57 a.m., the surveyor observed O/ULP-E administer medications for R3. On July 29, 2026, at 9:34 a.m., LALD-D stated they completed their annual trainings but could not access Educare at this time to print off updated transcripts to include the annual training including dementia and deescalation training. LALD-D stated annual training for all of the employees had been completed, it was just a matter of getting the documentation from Educare. LALD-D stated annual training was completed on an employee's work anniversary. On July 29, 2026, at 12:24 p.m., O/ULP-E stated they had completed the required annual training topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 660			

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0 660	Continued From page 12 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 observation, interview, and record review, the licensee failed to conduct tuberculosis (TB) testing for one of three employees (owner/unlicensed personnel (O/ULP)-E). In addition, the licensee failed to conduct TB testing with either a Mantoux skin test or blood test prior to obtaining a chest X-Ray (CXR) for two of two employees (ULP-B, licensed assisted living director (LALD)-D)), and the licensee failed to ensure annual TB training was completed for two of three employees (ULP-B, O/ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment was completed on February 1, 2026. The licensee's	0 660			

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0 660	Continued From page 13 facility was at a low risk level for transmission of TB. ULP-B ULP-B was hired on January 17, 2025, to provide direct care to residents. ULP-B's Educare (online training platform) transcript indicated ULP-B last completed TB training on January 11, 2025. ULP-B's record included a CXR result dated January 23, 2023, which indicated ULP-B's lungs were clear. ULP-B's record lacked a correlating positive Mantoux or blood test completed within 90 days prior to the CXR. On July 27, 2026, at 12:20 p.m., the surveyor observed ULP-B assisting R2 with mobility in their wheelchair (w/c). LALD-D LALD-D was hired on January 29, 2025, to provide facility oversight and direct cares to residents. LALD-D's record included a CXR result, undated, which indicated ULP-B's lungs were clear. LALD-D's record lacked a correlating positive Mantoux or blood test completed within 90 days prior to the CXR. On July 26-28, 2026, the surveyor observed LALD-D performing oversight duties and assist the surveyor with the survey process. O/ULP-E O/ULP-E was hired on January 17, 2025, and provided ownerships duties and direct care to residents.	0 660			

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0 660	Continued From page 14 O/ULP-E's Educare transcript indicated O/ULP-E last completed TB training on January 9, 2025. O/ULP-E's record included a QuantiFERON-TB Gold Plus negative test result dated February 2, 2024, which was completed prior to O/ULP-E's date of hire. On July 29, 2026, at 7:57 a.m., the surveyor observed O/ULP-E administer medications for R3. On July 29, 2026, at 9:21 a.m., LALD-D stated they only had the CXR documentation for themselves and ULP-B. LALD-D stated they were going to try and get a copy of their TB test results. On July 29, 2026, at 12:54 p.m., LALD-D stated O/ULP-E had a test result to provide which was completed before they were hired. The surveyor explained all staff were required to have a TB test completed upon hire by the licensee. LALD-D stated, "but [they] worked at the hospital." The surveyor explained it was completed by another place of employment and a new one needed to be completed at the time of hire. The surveyor requested ULP-B and O/ULP-E's annual TB training. LALD-D stated they were still trying to gain access to staff Educare training but were having trouble accessing the software. LALD-D stated they would try calling Educare for a second time. LALD-D was unable to verify if the annual TB training had been completed. LALD-D stated training was completed on an employee's work anniversary and all training was assigned to be completed in Educare. On July 29, 2026, at 1:03 p.m., during the exit conference, LALD-D stated they would send the	0 660			

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0 660	Continued From page 15 surveyor an updated Educare transcript for ULP-B and O/ULP-E via email once they obtained access to the software. LALD-D stated they would send ULP-B and LALD-D's TB test result via email once they located them. The surveyor did not receive any additional TB documentation after the survey was completed. The Minnesota Department of Health TB FAQ, last updated on June 5, 2026, indicated, "Baseline TB screening is required at the time of hire for all health care personnel in Minnesota." Additionally, "All Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure risk factors (both occupational and nonoccupational), the signs and symptoms of TB disease, and TB infection control policies and procedures." It further indicated: "A CXR alone is not acceptable documentation. You either need: documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and a CXR with provider evaluation after that date or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record	0 730			

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0 730	Continued From page 16 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730			

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0 730	Continued From page 17 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for two of two residents (R2, R3). 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 R2 was admitted to the licensee on December 13, 2025. R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance, appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance,	0 730			

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0 730	Continued From page 18 medication administration, record BG, record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance. R2's Service Recap Summary for July 2026, indicated the licensee lacked documentation for the following services and dates: - activity assistance, lacked documentation on July 5, 10, 12, 14, 19, 21, and 23-25; - bed mobility/repositioning, lacked documentation on July 10, 14, 19, 21, and 24-26; - bed making, lacked documentation on July 10, 14, and 23-26; - behavior and symptom management for anxiety and depression, lacked documentation on July 2, 10, 12, 14, 15, 19, 21, and 25; - dressing, lacked documentation on July 2, 10, 19, and 23-26; - drinking assistance, lacked documentation on July 5, 10, 14, 15 19, 21, and 23-26; - grooming, lacked documentation on July 10, 19, and 24-26; - housekeeping heavy/light, lacked documentation on July 2, 10, 19, 24, and 25; - incontinence care, lacked documentation on July 10, 24, and 25; - laundry, lacked documentation on July 5, and 19; - linen change, lacked documentation on July 5, 19, and 26; - meal assistance, lacked documentation on July 10, 19, 24, and 25; - medication administration, lacked documentation on July 1-3, 5-10, and 12-26; - record blood glucose (BG), lacked documentation on July 23; - record blood pressure (BP), lacked documentation on July 1-3, 9, 10, 21, 22, 24, and 25;	0 730			

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0 730	Continued From page 19 - record weight, lacked documentation on July 6; - safety checks, lacked documentation on July 1, 3, 4, 9, 10, 13-15, and 17-25; - shopping assistance, lacked documentation on July 23; - socialization, lacked documentation on July 2, 5, 10, 12, 14, 15, and 23-25; and - toileting, lacked documentation on July 10, 24, and 25. R3 R3 was admitted to the licensee on December 13, 2025. R3's Service Plan dated July 13, 2026, indicated R3 received services for ambulation, appointment reminders, bathing reminders, dressing, grooming, housekeeping heavy/light, incontinence care, laundry, linen change, manage behavior for agitation, manage behavior for anxiety, manage behavior for paranoia, meal assistance, medication administration, pendant check, recording blood pressure, recording oxygen saturation, recording pulse, recording weight, safety check, shopping assistance, snack, socialization, and transportation assistance. R3's Service Recap Summary for July 2026, indicated the licensee lacked documentation for the following services and dates: - ambulation, lacked documentation on July 10, 13, 19, 20, 23, 24, and 25; - bathing reminder, lacked documentation on July 10, 19, 21, 24, and 25; - dressing, lacked documentation on July 10, 19, 21, 24, and 25; - grooming, lacked documentation on July 10, 19, 24, and 25; - housekeeping heavy, lacked documentation on	0 730			

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0 730	Continued From page 20 July 19; - housekeeping light, lacked documentation on July 2, 10, 19, 24, and 25; - incontinence care, lacked documentation on July 1, 4, 6, 9, 10, 13-15, and 17-25; - laundry, lacked documentation on July 19 and 26; - linen change, lacked documentation on July 5; - manage agitation, lacked documentation on July 1, 2, 4, 10, 12-15, and 17-25; - manage anxiety, lacked documentation on July 1, 2, 4, 10, 12-15, and 17-25; - manage paranoia, lacked documentation on July 1, 2, 4, 10, 12-15, and 17-25; - meal assistance, lacked documentation on July 4, 10, 13-15, and 21-25; - medication administration lacked documentation on July 23; - pendant, lacked documentation on July 13, 20, and 23; - record blood pressure, lacked documentation on July 1-3, 9, 10, 15, 21, 22, 24 and 25; - record oxygen saturation, lacked documentation on July 5; - record pulse, lacked documentation on July 5; - record weight, lacked documentation on July 5; - safety check, lacked documentation on July 1, 4, 9, 10, 12-15, and 17-25; - shopping, lacked documentation on July 23; - snack, lacked documentation on July 4, 13-15, 17-25; - socialization, lacked documentation on July 12, 14, 15, 21, 23 and 24; On July 27, 2026, at 1:49 p.m., the surveyor observed ULP-C socializing with R2 and R3. On July 29, 2026, at 1:03 p.m., clinical nurse supervisor (CNS)-A stated they thought service documentation was being completed by the ULPs	0 730			

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0 730	Continued From page 21 and had not done any auditing of the resident records for R2 or R3. CNS-A stated ULPs were trained by the previously employed CNS and assumed it meant they were competent but now understood they needed to do retraining. On July 29, 2026, at 1:03 p.m., the surveyor requested a service documentation policy via email but one was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 790 SS=A	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; 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.	0 790			

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0 790	Continued From page 22 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 790			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810			

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0 810	Continued From page 23 (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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute	0 810			

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0 810	Continued From page 24 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=I	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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 830			

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0 830	Continued From page 25 Environment Inspection Report (PEIR) dated July 27, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that has not potential to cause more than a 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 potential to affect a large portion or all of the residents).	0 910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE HEALTH CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 IRVING LANE NORTH BROOKLYN CENTER, MN 55430			
(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
0 910	Continued From page 26 The findings include: The licensee's blank Assisted Living Contract template lacked the licensee's health facility identification number (HFID) 41108. R2 was admitted to the licensee on December 13, 2025. R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance, appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance, medication administration, record BG, record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance. R2's Assisted Living Contract, signed December 13, 2025, was the same as the above-mentioned blank contract and lacked HFID 41108. On July 29, 2026, at 11:54 a.m., licensed assisted living director (LALD)-D stated the above-mentioned blank contract template was used for both R2 and R3. LALD-D stated they had all of the required information in their contract, but they hired a consultant who reworked the contract for them and the consultant removed a lot of the items including the HFID number. No further information was provided.	0 910			

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0 910	Continued From page 27	0 910			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R2).	0 920			

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0 920	Continued From page 28 This practice resulted in a level one violation (a violation that has not potential to cause more than a 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 potential to affect a large portion or all of the residents). The findings include: The licensee's blank Assisted Living Contract template lacked the following required information: - a delineation of the cost and nature of any other services to be provided for an additional fee; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; and - disclosure of the facility's ability to provide specialized diets. R2 was admitted to the licensee on December 13, 2025. R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance, appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance, medication administration, record BG, record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance.	0 920			

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0 920	Continued From page 29 R2's Assisted Living Contract, signed December 13, 2025, was the same as the above-mentioned blank contract and lacked the following required information: - a delineation of the cost and nature of any other services to be provided for an additional fee; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; and - disclosure of the facility's ability to provide specialized diets. On July 29, 2026, at 11:54 a.m., licensed assisted living director (LALD)-D stated the above-mentioned blank contract template was used for both R2 and R3. LALD-D stated they had all of the required information in their contract, but they hired a consultant who reworked the contract for them and the consultant removed a lot of the items including the above-mentioned information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950			

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0 950	Continued From page 30 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide residents with the required verbatim notice on a document separate from the contract to elect or decline a designated representative one of one residents (R2). 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:	0 950			

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0 950	Continued From page 31 The licensee's blank Assisted Living Contract template lacked the required verbatim designated representative language; it included the following: "Resident has the right to name an individual of their choice as "Designated Representative" for the purposes of receiving certain information and to whom Provider can go to with questions related to Resident's residency and care at Bridge Health Care Services. If a Responsible Person is party to this Contract and Resident fails to name and provide contact information for a Designated Representative, Provider will direct questions related to Resident's residency and care at Bridge Health Care Services to the Responsible Person. Resident may name as Resident's Designated Representative an individual serving as Resident's Responsible Person. Resident also has the right to decline to name a Designated Representative, regardless of whether an individual has agreed to execute this Contract as Resident's Responsible Person." R2 was admitted to the licensee on December 13, 2025. R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance, appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance, medication administration, record BG, record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance. R2's Assisted Living Contract, signed December	0 950			

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0 950	Continued From page 32 13, 2025, was the same as the above-mentioned blank contract and lacked the required verbatim language. On July 29, 2026, at 11:54 a.m., licensed assisted living director (LALD)-D stated the above-mentioned blank contract template was used for both R2 and R3. LALD-D stated they had all of the required information in their contract, but they hired a consultant who reworked the contract for them and the consultant changed the designated representative language. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	01440			

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01440	Continued From page 33 individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for three of three employees (unlicensed personnel (ULP)-B, licensed assisted living director (LALD)-D, owner/ULP (O/ULP)-E). 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-B ULP-B was hired on January 17, 2025, to provide direct care to residents. On July 27, 2026, at 12:20 p.m., the surveyor observed ULP-B assisting R2 with mobility in their wheelchair (w/c). ULP-B's record lacked documentation of a RN 30-day supervision of ULP-B providing deligated nursing tasks.	01440			

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01440	Continued From page 34 LALD-D LALD-D was hired on January 29, 2025, to provide facility oversight and direct cares to residents. On July 26-28, 2026, the surveyor observed LALD-D performing oversight duties and assist the surveyor with the survey process. LALD-D's record lacked documentation of a RN 30-day supervision of LALD-D providing deligated nursing tasks. O/ULP-E O/ULP-E was hired on January 17, 2025, and provided ownerships duties and direct care to residents. On July 29, 2026, at 7:57 a.m., the surveyor observed O/ULP-E administer medications for R3. ULP-E's record lacked documentation of a RN 30-day supervision of ULP-E providing deligated nursing tasks. On July 27, 2026, at 9:59 a.m., clinical nurse supervisor (CNS)-A stated they did not have access to the RN 30-day function in Residex (charting software) where the RN 30-day supervisions were stored. CNS-A stated there had been no new employees hired since they were hired on February 4, 2026. On July 27, 2026, at 2:32 p.m., CNS-A stated they had not done any RN supervisions of staff since they were hired. On July 29, 2026, at 1:03 p.m., CNS-A stated they were not employed by the licensee when	01440			

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01440	Continued From page 35 ULP-B, LALD-D and O/ULP-E were hired and was unsure if the previously employed CNS had completed a RN 30-day supervision. A policy addressing RN 30-day supervisions was requested but one was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01730 SS=I	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730			

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01730	Continued From page 36 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. 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) provided clear administration instructions to unlicensed personnel (ULP) for one of two residents who received medication administration services (R2). In addition, the RN failed to ensure medications were accurately transcribed, reconciled, clarified, and documented to prevent possible complications or adverse reactions. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	01730			

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01730	Continued From page 37 portion or all of the residents). The findings include: The licensee was licensed for a capacity of five residents and had a census of two residents at the time of the survey. Both residents received medication administration services. One of the two residents received insulin administration. R2 was admitted to the licensee on December 13, 2025. R2's diagnoses included diabetes insipidus (primary), depression, anxiety disorder, and auditory hallucinations. R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance, appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance, medication administration, record BG, record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance. R2's record included Providers Orders dated January 28, 2026, which indicated R2 took the following medications: -insulin aspart 100 units (u)/milliliter (ml) pen; inject 3-9u subcutaneously (SQ) under the skin three times daily with meals containing carbohydrates as directed; and -Lantus Solostar pen 100u/ml; inject 10u SQ one time daily.	01730			

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01730	Continued From page 38 R2's Medication Admin Record (MAR) for July 2026, indicated R2 took the following medications: -insulin aspart 100 units (u)/milliliter (ml) pen; inject 3-9u SQ under the skin three times daily with meals containing carbohydrates as directed; it was administered at 8:00 AM on July 1-27, 12:00 PM July 1, 3-26 and 5:00 PM July 1-22, 24-26; and -Lantus Solostar pen 100u/ml; inject 12u SQ one time daily; it was administered at 7:00 PM on July 1-22, 24-26, 2026. Clinical nurse supervisor (CNS)-A was hired on February 4, 2026, to provide clinical oversight to residents and staff. On July 27, 2026, at 2:28 p.m., CNS-A provided orders faxed to them from the pharmacy which were requested during the survey in the surveyor's presence after the surveyor questioned R2's insulin aspart and Lantus orders. The faxed pharmacy orders were as follows: -insulin aspart 100 units (u)/milliliter (ml) pen; inject 3-9u SQ under the skin three times daily with meals containing carbohydrates as directed; and -Lantus Solostar pen 100u/ml; inject 10u SQ one time daily. On July 27, 2026, at 1:32 p.m., the surveyor inquired how much Lantus insulin R2 was supposed to be getting as the MAR indicated the facility was administering 12u and the order indicated to administer 10u. The surveyor observed CNS-A go to the medication refrigerator to look at R2's insulin label for the Lantus. The unused insulin pens were stored in a bag in the refrigerator which contained the pharmacy	01730			

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01730	Continued From page 39 prescription label; the insulin pens were not labeled. CNS-A stated R2 was supposed to be getting 10u of Lantus insulin, not 12u. On July 27, 2026, at 2:28 p.m., CNS-A provided R2's insulin orders from the pharmacy and stated R2's Lantus order was for 10u, and it was a transcription error the previous nurse made when they entered the order into Residex (charting software). In addition, CNS-A stated R2's insulin aspart order remained the same as they had on their MAR, which gave no parameters for determining how many units to give during administration. On July 27, 2026, at 1:49 p.m., the surveyor observed unlicensed personnel (ULP)-C sitting outside with R2. The surveyor observed CNS-A question ULP-C how many units of insulin aspart they had been administering R2. ULP-C stated 6-8u. The surveyor looked in Residex on the licensee's tablet and stated it indicated to give 3-9u. ULP-C stated they did not know at what level of BG they should hold R2's insulin. ULP-C then stated they would hold the insulin if R2 did not eat their meal. The surveyor inquired how they knew how many units of insulin to give R2 since there was an insulin unit range but no instruction on how to determine how much to give. ULP-C stated they did not know but they were told by the previous nurse to give 8u but said the information was not in the Residex order. ULP-C stated they received insulin administration training from the previously employed nurse but had no training or observation from CNS-A. On July 27, 2026, at 2:09 p.m., the surveyor inquired if the number of units of Lantus and insulin aspart administered to R2 were part of their documentation. The surveyor observed	01730			

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01730	Continued From page 40 CNS-A looking through Residex on their laptop; CNS-A stated the number of units staff administered were not documented. On July 27, 2026, at 2:12 p.m., the surveyor inquired from CNS-A if they had any additional order instructions for R2's insulin aspart as there were no instructions on how to determine the number of units of insulin should be administered, only a range of 3-9u was given. CNS-A stated the order did lack information to determine how much insulin to administer to R2. CNS-A stated the prescriber did not put any specifics on the order for them to follow; they stated they did not follow up with the prescriber to clarify the order. On July 27, 2026, at 2:24 p.m., the surveyor observed CNS-A call R2's clinic to get clarification for R2's Lantus and insulin aspart orders; CNS-A left a message with a staff member. On July 27, 2026, at 2:28 p.m., CNS-A again stated R2's Lantus unit dosage to administer 12u on the MAR in Residex was a transcription error. On July 27, 2026, at 2:32 p.m., licensed assisted living director (LALD)-D and CNS-A stated the normal process they followed for new prescriptions was the resident's providers sent new medication orders directly to the pharmacy and the pharmacy then entered the order into a system (Pharmacy Connect) where CNS-A must acknowledge and approve or decline the order. CNS-A then enters the order onto the MAR in Residex. CNS-A stated they only get notified of new orders that way, but they did not get notified if there was a discontinued medication order. CNS-A stated LALD-D normally notified them of when residents had medical appointments and stated LALD-D handled the appointments.	01730			

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01730	Continued From page 41 However, LALD-D stated they did not always notify the nurse when there was an appointment. CNS-A stated it was their responsibility to update a resident's MAR, and it was evident the licensee had a communication problem. CNS-A agreed that the insulin discrepancies for R2 were concerning and stated they had not conducted medication reconciliations for either R2 or R3. CNS-A stated they should have been checking the medication orders to ensure they were up to date and stated they had not conducted any medication or insulin administration training for their ULPs; the only training the ULPs had received was from the previously employed nurse. CNS-A stated they had observed some as needed (PRN) medication administration but had never observed insulin administration or any other scheduled medications. CNS-A stated they were never at the facility at 8:00 a.m., or 8:00 p.m., so they were unable to observe those medication passes. CNS-A stated they also oversee five other facilities for a total of six, four of which were under different ownership umbrella. CNS-A stated they normally spend about 1-2 hours per week at the licensee's facility. CNS-A stated they were in the process of hiring a backup nurse who would be a PRN nurse, but asserted they had enough time to conduct their nursing duties as required. When the surveyor inquired if CNS-A were to come to the facility to administer R2's insulin, how as a licensed professional they would interpret R2s insulin aspart order range from 3-9u for administration, CNS-A stated if they were to administer R2's Lantus or insulin aspart, they would need to contact the provider to have the orders clarified. CNS-A stated they assumed the orders for the insulin aspart were the same orders the previously employed nurse had entered into Residex, then stated, "which we should never assume," someone put in the orders	01730			

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01730	Continued From page 42 correctly. CNS-A stated they think the Lantus order was a typo. On July 27, 2026, at 3:01 p.m., CNS-A stated ULP's were trained to hold insulin administration if a resident's BG levels were under 100. On July 27, 2026, at 3:06 p.m. CNS-A stated when they were hired, they did not want to feel pushy, the owners told CNS-A everything was in order. CNS-A stated one of the owners was a pharmacist and they told CNS-A everything with the medications was in order. CNS-A stated, "I'm just too trusting." CNS-A stated they should have verified the medications themselves. On July 27, 2026, at 3:09 p.m., CNS-A stated they were putting R2's insulin aspart order on hold until they could hear back from R2's clinic and provider. On July 27, 2026, at 3:28 p.m., the surveyor observed R2's medication cabinet with LALD-D. R2's Lantus and insulin aspart injection pens all lacked resident identifying information or a pharmacy label with administration instructions. On July 27, 2026, at 3:30 p.m., ULP-C had difficulty explaining the medication administration process and the surveyor had to walk them through it. ULP-C stated they would hold R2's insulin if they had a BG result below 100. On July 27, 2026, at approximately 3:35 p.m., after LALD-D overheard the survey supervisor's (SS) discussion with CNS-A about insulin concerns, LALD-D came upstairs to where SS was working and stated the licensee's previously employed nurse told all staff to always administer 7-8u of insulin aspart to the resident. SS inquired	01730			

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01730	Continued From page 43 how LALD-D knew that information. LALD-D stated, "I was there," and further explained they also functioned as a ULP who passed medications at the facility. On July 28, 2026, at 7:48 a.m., the surveyor observed the medication cabinet with ULP-E who had the keys for their shift. The surveyor observed R2's insulin pens still lacked labeling with R2's identifying information and medication administration instructions. On July 28, 2026, at 7:52 a.m., ULP-E stated they still had not received any instruction or observation from CNS-A as of that time. ULP-E stated since there were no labels on R2's insulin pens they were only going off of R2's MAR to administer the Lantus and insulin aspart. ULP-E stated they usually gave 8-9u of aspart as it was what the previously employed nurse had instructed them to do. ULP-E stated CNS-A had never given them any instruction on what dose of insulin aspart they should administer for R2. ULP-E stated they had not questioned CNS-A about R2's medication or insulin orders, only the previously employed nurse. ULP-E stated they did not work evenings so they had never administered R2's Lantus. ULP-E stated all of their training was completed by the previously employed nurse; they received no instruction from CNS-A. ULP-E stated they would hold R2's insulin if R2 had a BG result less than 70. ULP-E stated they would contact the nurse if R2's BG result were below 70 or above 300. On July 28, 2026, at 8:08 a.m., ULP-C stated CNS-A did not talk to them about the insulin situation for R2 but did read the Residex popup message CNS-A entered. ULP-C stated they still had not received any instruction or observation	01730			

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01730	Continued From page 44 from CNS-A at this time. ULP-C stated they would normally compare the medication labels to the MAR when preparing medications for administration but were unable to do that with R2's insulin since they lacked labels. On July 28, 2026, at 8:18 a.m., LALD-D stated they do perform medication administration. LALD-D stated they hold R2's insulin if they have a BG result below 120. LALD-D stated there were some instances where they would hold R2's insulin if R2's BG result was below 150 as they worried R2's BG would drop too low. LALD-D stated they were administering 7-8u of insulin to R2 per the instructions given to them by the previously employed nurse. LALD-D stated they thought CNS-A had given instructions on how much insulin to administer for R2 but could not remember what CNS-A had told them. LALD-D stated R2's insulin pens were unlabeled, but they only had one resident who took insulin. The surveyor explained that without labels they were unable to check the insulin pen against the MAR orders. LALD-D stated they had never questioned CNS-A about R2's insulin. LALD-D stated R2 took 12u of Lantus; the surveyor corrected LALD-D and stated R2 took 10u of Lantus. LALD-D stated CNS-A had talked to and sent out text messages to other ULP staff about R2's insulin. The surveyor explained that both ULP-C and ULP-E stated the only communication they received from CNS-A was a popup message in Residex; LALD-D did not respond. ULP-E who was present questioned what CNS-A was supposed to do, come to the facility and educate everyone who comes into work? The surveyor explained that CNS-A should do what needed to be done to ensure staff were properly educated. On July 28, 2026, at 8:43 a.m., CNS-A stated	01730			

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01730	Continued From page 45 they had not yet heard back from R2's clinic. CNS-A stated they were currently developing an insulin training program and conducting a root cause analysis. Despite having worked at the facility for nearly six months, CNS-A lacked insight and awareness into R2's medication management. CNS-A did not have R2's medication orders available on-site for reference, failed to complete a medication reconciliation, did not provide clear administration instructions for ULP, and failed to follow up to clarify physician's orders for medications which resulted in on-going errors and increased risk for potential harm to the resident. The manufacturer instructions for Lantus Solostar insulin pens, revised May 2025, indicated: "----- WARNINGS AND PRECAUTIONS ----- · Never share a LANTUS SoloStar prefilled pen, insulin syringe, or needle between patients, even if the needle is changed. (5.1) · Hyperglycemia or hypoglycemia with changes in insulin regimen: Make changes to a patient's insulin regimen (e.g., insulin strength, manufacturer, type, injection site or method of administration) under close medical supervision with increased frequency of blood glucose monitoring. (5.2) · Hypoglycemia: May be life-threatening. Increase frequency of glucose monitoring with changes to: insulin dosage, concomitant drugs, meal pattern, physical activity; and inpatients with renal or hepatic impairment and hypoglycemia awareness. (5.3) · Hypoglycemia due to medication errors: Accidental mix-ups between insulin products can occur. Instruct patients to check insulin labels before injection. (5.4)	01730			

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01730	Continued From page 46 · Hypersensitivity reactions: Severe, life-threatening, generalized allergy, including anaphylaxis, can occur. Discontinue LANTUS. Monitor and treat if indicated. (5.5) · Hypokalemia: Maybe life-threatening. Monitor potassium levels in patients at risk of hypokalemia and treat if indicated. (5.6) · Fluid retention and heart failure with concomitant use of thiazolidinediones (TZDs): Observe for signs and symptoms of heart failure; consider dosage reduction or discontinuation of TZD if heart failure occurs. (5.7) ----- ADVERSE REACTIONS ----- Adverse reactions commonly associated with LANTUS include hypoglycemia, allergic reactions, injection site reactions, lipodystrophy, pruritus, rash, edema, and weight gain. (6.1)." The manufacturer instructions for Novolog (insulin aspart) injection pen, dated March 2023, indicated: -- WARNINGS AND PRECAUTIONS -- Never share a NOVOLOG® FlexPen® or a NOVOLOG® FlexTouch®, PenFill® cartridge or PenFill® cartridge device between patients, even if the needle is changed (5.1). · Hyperglycemia or hypoglycemia with changes in insulin regimen: Make changes to a patient's insulin regimen (e.g., insulin strength, manufacturer, type, injection site or method of administration) under close medical supervision with increased frequency of blood glucose monitoring (5.2). · Hypoglycemia: May be life-threatening. Increase frequency of glucose monitoring with changes to: insulin dosage, concomitantly administered glucose lowering medications, meal pattern, physical activity; and in patients with renal or hepatic impairments and hypoglycemia	01730			

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01730	Continued From page 47 unawareness (5.3). - Medication Errors: Accidental mix-ups between insulin products can occur. Instruct patients to check insulin labels before injection (5.4). - Hypersensitivity reactions: Severe, life-threatening, generalized allergy, including anaphylaxis, may occur. Discontinue NOVOLOG®, treat, and monitor, if indicated (5.5). - Hypokalemia: May be life-threatening. Monitor potassium levels in patients at risk of hypokalemia and treat if indicated (5.6). - Fluid retention and heart failure with concomitant use of thiazolidinediones (TZDs): Observe for signs and symptoms of heart failure; consider dosage reduction or discontinuation if heart failure occurs (5.7). - Hyperglycemia and Ketoacidosis Due to Insulin Pump Device Malfunction: Monitor glucose and administer NOVOLOG® by subcutaneous injection if pump malfunction occurs (5.8). --- ADVERSE REACTIONS --- Adverse reactions observed with NOVOLOG® include: hypoglycemia, allergic reactions, local injection site reactions, lipodystrophy, rash, and pruritus (6). The licensee's 7.20 Medication & Treatment Orders policy dated October 10, 2026, indicated: "POLICY: To ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. PROCEDURE: 1) The RN is responsible for assuring that:	01730			

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01730	Continued From page 48 a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. 7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. 8) A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance."	01730			

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01730	Continued From page 49 The licensee's 7.36 Insulin policy dated October 10, 2024, indicated: "POLICY: Only properly trained staff of Bridge Health Care Services may provide medication assistance or administration. ULP must be trained, and competency tested by a RN, with documentation on file. Insulin medications must be administered according to the prescribers' orders. PROCEDURE: 1. Medications always need to be administered according to the "6 Rights" -Right person -Right medication -Right time -Right route (i.e., by mouth, eye drop, to the skin) -Right dose (i.e., how many milligrams, drops) -Right chart/record to document that the medication was taken 2. Some important tips to remember when assisting residents with self-administered insulin medications are: A. Always know what medications you are giving, what effect they have, and what their side effects are. If you are not sure about any medications, check your medication reference manual and/or call the nurse. B. Medications should be set up, given to the individual, and documented by the same staff member. Do not give out medications that another person has set up. C. To avoid confusion, it is best to give the medications as quickly as possible after they are set up. Set up the medications for one person, give them to the person, and document that they were given before you set up the medications for the next person. D. Always wash your hands before setting up medications and at any time during the process if	01730			

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01730	Continued From page 50 your hands have been contaminated. (See hand washing procedure) E. Compare the information of the MAR with the label on the medication container. The following information should be in all the places: -Resident name -Name of the medication -The strength and dosage of the medication -The route -The time that the medication is to be given -Any special instructions F. If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same. 3. Read the label and compare it with the information on the MAR three (3) times to make sure that you haven't made a mistake." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01730			
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	01760			

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01760	Continued From page 51 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff documented medication administration for two of two residents (R2, R3). 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 R2 was admitted to the licensee on December 13, 2025. R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance, appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance, medication administration, record blood glucose (BG), record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance. R2's Med Admin Summary (medication	01760			

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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
01760	Continued From page 52 administration record (MAR)) for July 2026, lacked the following documentation: -atorvastatin tablet 80 milligrams (mg), take one tablet by mouth (PO) every day at bedtime; lacked documentation on July 23; -diclofenac tablet 75mg, take one tablet PO twice daily with meals; lacked documentation on July 20 and 23; -Eliquis tablet 5mg, take one tablet PO twice daily; lacked documentation on July 23; -insulin aspart 100 u/ml pen; inject 3-9u subcutaneously (SQ) under the skin three times daily with meals containing carbohydrates as directed; lacked documentation on July 2 and 26 at 12:00 p.m. and July 23 at 5:00 p.m.; -Lantus Solostar pen 100u/ml; inject 12u SQ one time daily; lacked documentation on July 23; -metformin tablet 500mg tablet, take one tablet PO twice daily, lacked documentation on July 23; -ondansetron tablet 4mg, dissolved one tablet 4mg on tongue three times a day; lacked documentation on July 1 and 23; -Ozempic injection 4mg/3ml, inject 0.75ml (1mg) SQ once every week on Saturdays; lacked documentation on July 18 and 25; and -pregabalin capsule 150mg, take one capsule PO twice daily; lacked documentation on July 23. R3 R3 was admitted to the licensee on December 13, 2025. R3's Service Plan dated July 13, 2026, indicated R3 received services for ambulation, appointment reminders, bathing reminders, dressing, grooming, housekeeping heavy/light, incontinence care, laundry, linen change, manage behavior for agitation, manage behavior for anxiety, manage behavior for paranoia, meal assistance, medication administration, pendant	01760			

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01760	Continued From page 53 check, recording blood pressure, recording oxygen saturation, recording pulse, recording weight, safety check, shopping assistance, snack, socialization, and transportation assistance. R3's Med Admin Summary (medication administration record (MAR)) for July 2026, lacked the following documentation: -atorvastatin tablet 80 mg, take one tablet by PO every day at bedtime; lacked documentation on July 23; and -metformin tablet 500mg, take one tablet PO daily with meal; lacked documentation on July 23. On July 29, 2026, at 7:57 a.m., the surveyor observed O/ULP-E administer medications for R3. On July 27, 2026, at 2:32 p.m., clinical nurse supervisor (CNS)-A stated they did not provide medication administration documentation training. CNS-A stated the previously employed CNS did all of the ULP training. On July 27, 2026, at 3:06 p.m., CNS-A stated when they started with the licensee they did not want to feel pushy with the owners. CNS-A stated one of the owners was a pharmacist and they stated everything with the medications were in order. CNS-A stated, "I'm just too trusting." CNS-A stated they should have checked everything with the facility. On July 29, 2026, at 1:03 p.m., CNS-A stated they had not done any medication administration audits of R2 or R3's MAR's. On July 29, 2026, at 1:03 p.m., the surveyor requested a medication documentation policy via	01760			

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01760	Continued From page 54 email but one was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01760			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two residents (R2, R3). 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 December 13, 2025. R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance,	01820			

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01820	Continued From page 55 appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance, medication administration, record blood glucose (BG), record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance. R2's Provider Orders signed on January 28, 2026, indicated R2 took the following medications: -aspirin low chewable tablet 81 milligrams (mg), take one tablet by mouth (PO) daily; and -insulin aspart 100 units (u)/milliliter (ml) pen; inject 3-9u SQ under the skin three times daily with meals containing carbohydrates as directed; it was administered at 8:00 AM on July 1-27, 12:00 PM July 1, 3-26 and 5:00 PM July 1-22, 24-26. R2's Med Admin Summary (medication administration record (MAR)) for July 2026, indicated R2 took the following medications: -insulin aspart 100 u/ml pen; inject 3-9u SQ under the skin three times daily with meals containing carbohydrates as directed; it was administered at 8:00 AM on July 1-27, 12:00 PM July 1, 3-26 and 5:00 PM July 1-22, 24-26. R2's record lacked an order to discontinue R2's aspirin. R2's record insulin aspart order lacked parameters to indicate how much insulin to administer to R2 by licensed and unlicensed personnel (ULP).	01820			

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01820	Continued From page 56 On July 27, 2026, at 1:14 p.m., the surveyor questioned why R2 had an orders for aspirin but was not on R2's MAR as being an order medication they were administering. Clinical nurse supervisor (CNS)-A stated R2's aspirin had been discontinued on January 26, 2026. The surveyor explained the signed orders on January 28, 2026, indicated they were supposed to be administering aspirin for R2. CNS-A stated they would contact the pharmacy to get a copy of the discontinue order for R2's aspirin. On July 27, 2026, at 1:35 p.m., the surveyor requested current orders for ondansetron, topiramate and Ozempic. On July 27, 2026, at 1:49 p.m., the surveyor observed unlicensed personnel (ULP)-C sitting outside with R2 and R3 socializing. The surveyor observed CNS-A question ULP-C how many units of insulin aspart they had been administering R2. ULP-C stated 6-8u. The surveyor looked in Residex on the licensee's tablet and stated it indicated to give 3-9u. ULP-C stated they did not know at what level of BG they should hold R2's insulin. ULP-C then stated they would hold the insulin if R2 did not eat their meal. The surveyor inquired how they knew how many units of insulin to give R2 since there was an insulin unit range but no instruction on how to determine how much to give. ULP-C stated they did not know but they were told by the previous nurse to give 8u but said the information was not in the Residex order. ULP-C stated they received insulin administration training from the previously employed nurse but had no training or observation from CNS-A. On July 27, 2026, at 2:12 p.m., the surveyor inquired if they had additional orders for R2's	01820			

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01820	Continued From page 57 insulin aspart which clarified how much insulin aspart should be administered to R2. CNS-A said the doctor did not put any specific parameters on the order they had on file. CNS-A stated they did not follow up with the provider to clarify the insulin aspart order. On July 27, 2026, at 2:24 p.m., CNS-A called R2's clinic in the presence of the surveyors to get clarifying orders for R2's medications. On July 27, 2026, at 2:28 p.m., CNS-A provided prescriptions faxed to them on July 27, 2026, (during survey) by R2's pharmacy for ondansetron, topiramate, Ozempic and insulin aspart; the insulin aspart order from the pharmacy also lacked parameters for insulin aspart dose administration. On July 27, 2026, at 2:32 p.m., licensed assisted living director (LALD)-D stated they were present at R2's most resent doctor's appointment and they overheard the doctor say one of the blood thinners, aspirin or Eliquis, should be discontinued but they weren't sure which one; they were not given an order to discontinue either medication. CNS-A stated the medication order problems were their own fault. CNS-A stated if they had to administer R2's insulin aspart they would have had to contact R2's provider since the orders were incomplete. CNS-A stated they assumed the order was put in correctly by the previously employed CNS, "which we should never assume." CNS-A stated they were aware they should have had R2's orders onsite and should not have had to contact the pharmacy to get copies. On July 27, 2026, at 3:06 p.m., CNS-A stated when they started with the licensee they did not	01820			

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01820	Continued From page 58 want to feel pushy with the owners. CNS-A stated one of the owners was a pharmacist and they stated everything with the medications were in order. CNS-A stated, "I'm just too trusting." CNS-A stated they should have checked everything with the facility. The licensee's 7.17 Medication & Treatment Orders - Receiving policy dated October 10, 2026, indicated: "1. All orders for medications and treatments must be dated and signed by the prescriber, and must be current and consistent with the nursing assessment. 2. Content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. 3. Verbal orders received from a prescriber must have the RN/LPN: a. Record and sign the order. b. A record of the verbal order will be kept in the resident record c. All verbal orders received will be written- and then forwarded to the prescriber for the prescriber's signature. 4. Electronically transmitted orders: a. An order received by facsimile machine, or other electronic means must be received and kept confidential. b. An order received by facsimile machine, or other electronic means must be communicated to a licensed nurse within 1 hour of receipt. c. An order received by electronic means, not including facsimile machine, must be immediately recorded or placed in the resident's record by a nurse and must be countersigned by the prescriber if not already done so." No further information was provided.	01820			

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01820	Continued From page 59	01820			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for one of one resident (R2) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on December 13, 2025. R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance, appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking	01880			

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01880	Continued From page 60 assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance, medication administration, record BG, record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance. R2's Med Admin Summary (medication administration record (MAR)) for July 2026, indicated R2 took the following medications: -insulin aspart 100 units (u)/milliliter (ml) pen; inject 3-9u SQ under the skin three times daily with meals containing carbohydrates as directed; it was administered at 8:00 AM on July 1-27, 12:00 PM July 1, 3-26 and 5:00 PM July 1-22, 24-26; and -Lantus Solostar pen 100u/ml; inject 12u SQ one time daily; it was administered at 7:00 PM on July 1-22, 24-26, 2026. On July 27, 2026, at 10:23 a.m., the surveyor observed the medication refrigerator with licensed assisted living director (LALD)-D which lacked a thermometer to monitor the temperature. LALD-D stated they would get the thermometer they were using as they had been using it in another one of their refrigerators. LALD-D returned with a DeltaTrak needle food thermometer and was going to put it in the medication refrigerator. The surveyor explained the thermometer was a needle probe thermometer to check food temperatures. LALD-D then brought an identical DeltaTrak thermometer to use which was new and still in the packaging. Clinical nurse supervisor (CNS)-A stated to LALD-D the DeltaTrak thermometer was the wrong thermometer to use in the medication refrigerator and stated there was a classic red line	01880			

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01880	Continued From page 61 thermometer which was supposed to be in use. CNS-A and LALD-D searched for the thermometer but could not find it. The surveyor requested the medication refrigerator temperature log; CNS-A stated temperatures were logged in Residex (charting software) and they would provide it. On July 27, 2026, at 11:36 a.m., LALD-D provided the Residex Med Room Refrigerator temperature log printed on July 27, 2026. LALD-D stated some of the temperatures were logged in late due to Residex software issues and had to be handwritten on a paper log; the surveyor requested the paper logs. The Residex log indicated temperatures were entered into the log late or not at all for the following days: -July 1; no temperature was logged; -July 4; was entered into the log on July 17; -July 7; was entered into the log on July 20; -July 13 and 14; no temperature was logged; -July 21; was entered into the log on July 22; and -July 22-24; was entered into the log on July 27. On July 27, 2026, at 11:39 a.m., the surveyor followed LALD-D to the office and found LALD-D digging through piles of paper. LALD-D had a blank copy of a paper temperature log. LALD-D stated they were unable to locate the paper temperature log. The surveyor stated they had just entered the temperatures into the Residex temperature log 20 minutes prior; LALD-D stated they misplaced it. LALD-D provided a three-ringed binder with paper temperature logs which lacked paper temperature logs for every month in 2026 except for June and July. On July 27, 2026, at 11:43 a.m., LALD-D stated they still could not find the paper temperature logs.	01880			

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01880	Continued From page 62 On July 27, 2026, at 12:50 p.m., LALD provided the paper Medication Refrigerator Temperature Log dated July 2026, which did not account for all of the discrepancies of the Residex temperature log. LALD-D did not have an explanation for the discrepancies. The paper temperature log indicated temperatures were recorded on the following dates: -July 17; and -July 22-24. On July 29, 2026, at 1:03 p.m., CNS-A stated the refrigerator temperature logs were a problem and the staff would need to be retrained. Manufacturer's website for the DeltaTrack FlashCheck Lollipop Thermometer indicated its designed use was for food establishments, distribution centers, cold storage, and processing facilities. It was ideal for measuring the temperature of, "thin mass," food such as meat patties and chicken/fish fillets per the Food and Drug Administration (FDA) Food Code 4-302.12 (B). Manufacturer instructions for Lantus insulin pens, last revised in 2022, indicated to store unused Lantus insulin pens in a refrigerator between 36-46 degrees Fahrenheit (F); discard if Lantus has been frozen. Manufacturer instructions for Novolog, last revised March 2023, indicated to store unused Novolog insulin pens in a refrigerator between 36-46 degrees F; if it is stored between 47-86 degrees F it should be discarded after 28 days. On July 29, 2026, at 1:03 p.m., the surveyor requested a medication storage policy via email	01880			

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01880	Continued From page 63 but one was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin pens were labeled with resident identifying pharmacy labels for one of one resident (R2) with insulin. 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: R2 was admitted to the licensee on December 13, 2025.	01890			

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01890	Continued From page 64 R2's Service Plan dated July 13, 2026, indicated R2 received services for activity assistance, appointment reminders/assistance, bed mobility/repositioning, bed making, continuous blood glucose (BG) monitoring, dressing, drinking assistance, grooming, housekeeping heavy and light, incontinence care, laundry, linen change, manage depression and anxiety behaviors/symptoms, meal assistance, medication administration, record BG, record blood pressure, record weight, safety checks, shopping assistance, socialization, toileting, and transportation assistance. R2's Med Admin Summary (medication administration record (MAR)) for July 2026, indicated R2 took the following medications: -insulin aspart 100 units (u)/milliliter (ml) pen; inject 3-9u SQ under the skin three times daily with meals containing carbohydrates as directed; it was administered at 8:00 AM on July 1-27, 12:00 PM July 1, 3-26 and 5:00 PM July 1-22, 24-26; and -Lantus Solostar pen 100u/ml; inject 12u SQ one time daily; it was administered at 7:00 PM on July 1-22, 24-26, 2026. On July 27, 2026, at 3:28 p.m., the surveyor observed the medication cabinet with licensed assisted living director (LALD)-D. R2's insulin aspart pen and Lantus Solostar pen lacked resident identification labels. On July 28, 2026, at 8:08 a.m., unlicensed personnel (ULP)-C stated they normally would compare the MAR to the medication pharmacy label but since neither of R2's insulin pens had labels they were unable to do so during medication administration.	01890			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE HEALTH CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 IRVING LANE NORTH BROOKLYN CENTER, MN 55430		
(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
01890	Continued From page 65 On July 28, 2026, at 8:18 a.m., LALD-D stated R2's insulin pens were unlabeled, but they only had one resident, R2, with insulin. The surveyor explained the information was not just to identify the insulin as belonging to a specific resident, it was also for verifying the administration of the insulin order. On July 29, 2026, at 1:03 p.m., clinical nurse supervisor (CNS)-A stated the pharmacy they were using was unwilling to work with them by providing enough pharmacy labels for R2's insulin pens. CNS-A stated they switched to a different pharmacy yesterday, July 18, 2026, which they were familiar with and would provide them with the necessary pharmacy labels. CNS-A stated they were aware of the medication labeling requirements. On July 27, 2026, at 3:06 p.m., CNS-A stated when they started with the licensee they did not want to feel pushy with the owners. CNS-A stated one of the owners was a pharmacist and they stated everything with the medications were in order. CNS-A stated, "I'm just too trusting." CNS-A stated they should have checked everything the nurse was required to monitor with the facility. The licensee's 7.36 Insulin policy dated October 10, 2024, indicated: "E. Compare the information of the MAR with the label on the medication container. The following information should be in all the places: -Resident name -Name of the medication -The strength and dosage of the medication -The route -The time that the medication is to be given -Any special instructions	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE HEALTH CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 IRVING LANE NORTH BROOKLYN CENTER, MN 55430			
(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
01890	Continued From page 66 F. If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same. 3. Read the label and compare it with the information on the MAR three (3) times to make sure that you haven't made a mistake." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



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

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Establishment Info

BRIDGE HEALTH CARE SERVICES LL
1701 Irving Lane North
Brooklyn Center, MN 55430
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41108

Risk:
License:
Expires on:
CFPM: Abdiaziz H. Dhoore
CFPM #: 64250; Exp: 01/19/2029

Inspection Info

Report Number: F1021261210
Inspection Type: Full - Single
Date: 7/28/2026 Time: 11:07:36 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B Priority Level: Priority 2 CFP#: 36

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: ESTABLISHMENT HAD A DIAL THICK PROBE THERMOMETER ONSITE. PROVIDE A THIN PROBE DIGITAL FOOD THERMOMETER AS REQUIRED BY THE RULE ABOVE. DISCUSSED PROPER THERMOMETER PROBE SANITATION WITH STAFF AND OWNER.

Comply By: 8/4/2026 Originally Issued On: 7/28/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: NO TEST KIT ONSITE TO MEASURE THE CONCENTRATION OF SANITIZER. DISCUSSED THE APPROVED FOOD CONTACT SURFACE SANITIZERS AND THEIR APPROPRIATE TEST KITS. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 8/4/2026 Originally Issued On: 7/28/2026

New Order: 4-300 Equipment Numbers and Capacities

4-303.11B Priority Level: Priority 3 CFP#: 48

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

COMMENT: NO CHEMICAL SANITIZERS ONSITE. DISCUSSED WITH OWNER THE DIFFERENT APPROVED FOOD CONTACT SURFACE SANITIZERS. SANITIZER FACT SHEET SENT WITH REPORT. PROVIDE A CHEMICAL SANITIZER TO SANITIZE EQUIPMENT, UTENSILS AND FOOD CONTACT SURFACES.

Comply By: 7/28/2026 Originally Issued On: 7/28/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.14A Priority Level: Priority 3 CFP#: 10

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: HANDWASHING SINK IN THE KITCHEN IS MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 7/30/2026 Originally Issued On: 7/28/2026

Food & Beverage General Comment

All findings on this report were discussed with Owner, Ali Farah and Health Regulation Division Nurse Evaluator, Joey Keen.

This facility is a residential home. They currently have 2 clients and the facility can accommodate up to 5 clients.

Food is for same-day service. Leftovers are discarded at the end of service.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A temperature indicator was available on site to verify that the dishwasher reaches a utensil surface temperature of at least 160F. Staff will send the inspector a photo of the temperature indicator to confirm that the dishwasher is properly sanitizing.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

The kitchen has residential equipment, vinyl floor, laminate countertops, wood cabinets and painted drywall. Physical facility items will be monitored during future inspections.

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 F1021261210 from 7/28/2026



Ali Farah
Owner

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

BRIDGE HEALTH CARE SERVICES LL
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1021261210
Inspection Type: Full
Date: 7/28/2026
Time: 11:07:36 AM

Food Temperature: **Product/Item/Unit:** Milk ; **Temperature Process:** Cold-Holding

Location: LG Kitchen Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Sliced Chicken Deli Meat ; **Temperature Process:** Cold-Holding

Location: LG Kitchen Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** LG Kitchen Refrigerator ; **Temperature Process:** Ambient Air

Location: Kitchen at 35 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41108015-0	Date: July 27, 2026
Facility Name: Bridge Health Care Services LLC	
Facility Address: 1701 Irving Ln N, Brooklyn Center, MN 55430	

☒ TAG IDENTIFICATION: 0790

SCOPE/ SEVERITY: Level 1; Isolated

TIME PERIOD OF CORRECTION: Two (2) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguisher in the basement was mounted 66 inches above the finished floor. Fire extinguishers shall be mounted so the top of the extinguisher is no higher than 60 inches above the finished floor.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 3; 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 are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: During document review on July 27, 2026, at 12:00 p.m., and 12:14 p.m. the surveyor requested that licensed assisted living director (LALD)-D provide the FSEP, training documentation, and emergency drills. At 12:30 p.m. clinical nurse supervisor (CNS)-A printed an FSEP and provided it to the surveyor. CNS-A confirmed that they had printed the FSEP. The surveyor asked LALD-D if the FSEP was kept in a book or folder that was accessible to staff during normal business hours. LALD-D stated that they did not think it was.

2. 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish) 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.

3. 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.

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

Comments: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.

5. 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: During record review the surveyor requested LALD-D to provide resident training records on the FSEP at 12:00 p.m., 12:14 p.m., and 12:50 p.m. No resident training documentation was provided to review during the survey.

6. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-D provided documentation that showed 1 drill had been completed on February 2, 2026. No additional drill documentation was provided.

☒ **TAG IDENTIFICATION: 0830**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Facility complies with all state and local governing laws, and codes for fire safety, building, and zoning requirements. [Minn. Stat. 144G.45 subd.3]

Comments: There was a ramp in the living room that was 10 inches high, 36 inches wide, and 4 feet long. The ramp was too steep to meet Americans with Disabilities act requirements. The ramp also lacked a handrail or guardrail. When the surveyor asked LALD-D when the ramp was constructed, LALD-D said it was built by the owner without approval from the city and engineering services with the Department of Health.

On 07/28/2026 10:35 a.m. the surveyor observed resident 3 (R3) rolling resident 2 (R2) up the living room ramp, R3 got R2 near the top then turned around to grab something, R2 began rolling backwards down the ramp. CNS-A saw R2 rolling backwards down the ramp and moved quickly to grab a hold of the wheelchair R2 was in to prevent R2 from rolling backwards down the ramp and probably into R3.

Any alteration to a licensed assisted living facility must go through the plan review and approval process with the Minnesota Department of Health (MDH) and the Minnesota Department of Labor and Industry (DLI) or local building authority prior to starting construction or renovation. Any areas of completed construction work may not be permitted to be occupied by assisted living residents until the areas have been cleared for occupancy by the Engineering Services Department at MDH.