Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

August 13, 2026

Licensee
Hillside Harmony LLC
135 Geranium Ave East
Saint Paul, MN 55117

RE: Provisional Conditional License Number 422920
Health Facility Identification Number (HFID) 41832
Project Number(s) SL41832015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 9, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **November 11, 2026**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH 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 . . ."

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

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $2,000.00. **MDH is not imposing these fines against your provisional license at this time.**

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Hillside Harmony LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar

days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Hillside Harmony LLC is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new admissions:** Hillside Harmony LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Hillside Harmony LLC must provide the Department:

    i. A list of the names and birthdates of any individuals Hillside Harmony LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents including:
        1. Name and birthdate of each resident
        2. Current payment source for services
        3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Hillside Harmony LLC is in substantial compliance based on the results of the follow up . MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Hillside Harmony LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Hillside Harmony LLC. If MDH determines Hillside Harmony LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **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

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

If you have any questions, please contact Renee Anderson directly at: 651-201-5871 or email at: Renee.L.Anderson@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41832	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE HARMONY LLC	135 GERANIUM AVE E SAINT PAUL, MN 55117

(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: SL41832015-0 On July 7, 2026, through July 9, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 12 residents, 11 of whom were receiving services under the provider's Provisional Assisted Living Facility license. An immediate correction order was identified on July 9, 2026, issued for SL41832015-0, tag identification 1290.	0 000	Minnesota Department of Health is documenting the State Licensing 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 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 licensee after the commissioner is notified or has evidence that the provisional licensee is providing	0 180		

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0 180	Continued From page 1 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 observation, interview and record review, the licensee failed to notify the Minnesota Department of Health (MDH) within two days of starting to provide Assisted Living services. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 Facility license on November 25, 2025. The licensee's resident roster, dated July 7, 2026, indicated R7 was admitted March 10, 2026, and R1 was admitted March 20, 2026. The roster also included two residents, R4 and R6, who had previously lived at the licensee's sister-facility, HFID 33679. Their admit dates were listed as January 31, 2024, and July 15, 2024, and did not accurately reflect the date they began receiving services at the current facility. On July 7, 2026, at 11:50 a.m., the surveyor observed ULP-C assisting R1 with medication administration. On July 8, 2026, at 1:50 p.m., owner/licensed assisted living director (O/LALD)-A stated they had not submitted a Notice of Providing Assisted Living Services form to MDH. O/LALD-A stated they "forgot that piece." The Notice of Providing Services, submitted to the department via email on July 9, 2026, (after conclusion of the survey), indicated the licensee first began providing services on December 27, 2025. The licensee failed to provide notice to MDH within two days of licensee first providing assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 180		

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0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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	0 480		

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0 480	Continued From page 4 4626.1325, 4626.1335, and 4626.1360, item A, 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 7, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 5 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to post the emergency preparedness plan (EPP) prominently and failed	0 680		

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0 680	Continued From page 6 to have a written emergency preparedness (EP) plan with all the required content readily accessible. This had the potential to affect all residents, staff, and visitors during an emergency. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 7, 2026, at 10:00 a.m., during a facility tour, the surveyor observed the licensee's information wall. The wall lacked a posting of the licensee's EPP. On July 8, 2026, at 1:50 p.m., the surveyor requested a copy of the licensee's EPP. Owner/licensed assisted living director (O/LALD)-A stated the licensee was transitioning its software and they were in the process of "migrating" the plan. O/LALD-A stated they were not sure if they could access the EPP and would contact the software company for assistance. On July 9, 2026, at 1:13 p.m., via email, O/LALD-A provided the surveyor with an electronic copy of the licensee's EPP. The licensee's undated MN ALF Required Postings Compliance policy indicated the facility would post the disaster and emergency preparedness plan and it would be readily accessible to staff and residents.	0 680		

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0 680	Continued From page 7 Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record 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	0 730		

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0 730	Continued From page 8 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 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 (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 730		

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0 730	Continued From page 9 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: R1 R1's signed service plan, dated March 31, 2026, indicated R1 received services including assistance with activities, bedmaking, behavior management, bathing, dressing, grooming, housekeeping, oral and nail care, safety checks, dining, trash removal and wondering redirection. On July 7, 2026, at 11:50 a.m., the surveyor observed ULP-C assisting R1 with medication administration. R2 R2's signed service plan, dated April 20, 2026, indicated R2 received services including assistance with activities, bedmaking, behavior management, dressing, grooming, housekeeping, oral care, safety checks, toileting, transfers, dining escort, trash removal and oxygen saturation monitoring. On July 8, 2026, at 7:45 a.m., the surveyor observed ULP-C assisting R2 with medication administration. R1 and R2's Service Checkoff Lists for June 2026, and July 2026, pronted July 7, 2026, were identified by clinical nurse supervisor (CNS)-B as their documentation of services the licensee provided for R1 and R2. The Service Checkoff List documents included a line item for each service to be provided by the licensee and a box for every date and time of day where the staff	0 730		

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0 730	Continued From page 10 member who completed the service would initial when the service was provided or initial with a circle around their initials to indicate a service was not provided. R1 and R2's Service Recap Summary included dates that lacked documentation the scheduled services were provided as agreed upon in the Service Plan, or were declined/refused; the dates included: -June 1, 5-7, 9, 12-14, 18-20, 22, 25-27, and -July 1, 3-4, 6. On July 8, 2026, at 12:30 p.m., CNS-B, stated she was aware there was missing documentation for services provided and she would need to reeducate the staff. CNS-B further stated it could have been an oversite or perhaps an internet outage. The licensee's undated MN ALF 15-Element Resident Record Completeness (144G.43) policy indicated the licensee would ensure all services were documented per the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical	0 775		

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	41832	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 775	Continued From page 11 environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 12 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 13 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for	0 940		

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0 940	Continued From page 14 assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (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: R2 was admitted on April 16, 2026, with diagnosis of end stage renal disease. On July 8, 2026, at 7:45 a.m., the surveyor observed ULP-C assisting R2 with medication administration. R2's Resident Admission Agreement along with R2's Resident Handbook, dated April 15, 2026, was identified by owner/licensed assisted living director (O/LALD)-A as the licensee's assisted	0 940		

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0 940	Continued From page 15 living contract. The contract lacked the following required content: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided. - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. On July 9, 2026, at 12:55 p.m., O/LALD-A stated R2's contract was the same contract used for all residents. O/LALD-A stated they were not aware there was content missing from the contract, and they would have it corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under	01290		

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01290	Continued From page 16 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that, prior to working with residents, all employees had a cleared Minnesota Department of Human Services (DHS) NETStudy 2.0 background study for one of six employees (unlicensed personnel (ULP-D). This had the potential to affect all residents in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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: ULP-D was hired on April 1, 2026, to provide direct care services to residents. On July 7, 2026, at 11:20 a.m., clinical nurse supervisor (CNS)-B provided the surveyor with the Resident Associated Weekly Staff Schedule. The undated schedule indicated ULP-D worked from 1:30 p.m. to 10:00 p.m., Monday through Friday, and was the only ULP scheduled during that time on Tuesday and Wednesday. On July 7, 2026, from 2:37 p.m. to 2:55 p.m., the	01290	An immediate correction order was identified on July 9, 2026, issued for SL41832015-0, tag identification 1290. During the survey, the licensee took appropriate steps to mitigate the potential for immediate harm.	

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01290	Continued From page 17 surveyor observed ULP-D assisting R4, R5, and R6, respectively, with medication administration. ULP-D prepared the medications from a medication cart located in the hallway and entered each resident's room unsupervised to deliver the medications. ULP-D stated she had been working at the licensee's facility "four or five months," and had been trained by CNS-B on administering medications. On July 9, 2026, at 8:30 a.m., the surveyor observed the licensee's DHS NETStudy 2.0 background study roster online. The roster indicated ULP-D's background study was initiated July 6, 2026, and was "in process." The roster further indicated supervision of ULP-D was required. ULP-D's record lacked a cleared DHS background study affiliated with the licensee, completed at the time of hire. On July 9, 2026, at 8:55 a.m., CNS-B stated there were usually two ULP working together, but there were "moments" when ULP-D "can work alone." On July 9, 2026, at 10:47 a.m., owner/assisted living director (O/LALD)-A stated the weekly schedule provided was their routine weekly schedule. O/LALD-A further stated they "just realized" they had not completed ULP-D's background study properly and "I dropped the ball on that one." No further information was provided. TIME PERIOD OF CORRECTION: Immediate	01290		

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01370	Continued From page 18	01370		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 19 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations required for all unlicensed personnel were completed, prior to providing services, for one of one employee (unlicensed personnel (ULP)-C). 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-C was hired April 1, 2026, and provided direct care services to residents. On July 7, 2026, at 11:50 a.m., the surveyor observed ULP-C assisting R1 with medication administration. ULP-C's employee record lacked the following required trainings and competency evaluations: - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment. On July 7, 2026, at 1:43 p.m., clinical nurse supervisor (CNS)-B stated she reviews competencies for all unlicensed personnel, and	01370		

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01370	Continued From page 20 she did not realize there were missing items from the licensee's competency tracking form. CNS-B stated the missing training would be true for all hired ULP. The licensee undated MN ALF Staff Training Compliance Enforcement (144g.61, 144G.63, 144G.64) policy key requirements indicated staff would demonstrate competency in all required areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	01380		

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01380	Continued From page 21 Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations required for unlicensed personnel providing assisted living services were completed prior to providing services, for one of one employee (unlicensed personnel (ULP)-C). 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-C was hired April 1, 2026, and provided direct care services to residents. On July 7, 2026, at 11:50 a.m., the surveyor observed ULP-C assisting R1 with medication administration. ULP- C 's employee record lacked the following required trainings and competency evaluations: -recognizing physical, emotional, cognitive, and developmental needs of the resident. On July 7, 2026, at 1:43 p.m., clinical nurse supervisor (CNS)-B stated she reviewed competencies for all staff, and did not realize there were items missing from the licensee's competency tracking form. The licensee undated MN ALF Staff Training Compliance Enforcement (144g.61, 144G.63, 144G.64) policy key requirements indicated staff	01380		

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01380	Continued From page 22 would demonstrate competency in all required areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation	01530		

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01530	Continued From page 23 and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure required dementia care training and mental illness and de-escalation training were conducted within required timeframe for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). 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 was issued their Provisional Assisted Living Facility license on November 25, 2025. On July 7, 2026, at 11:20 a.m., CNS-B provided	01530		

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01530	Continued From page 24 the surveyor with the Resident Associated Weekly Staff Schedule. The schedule indicated that ULP-C worked Monday through Thursday 6:00 a.m., to 2:30 p.m. CNS-B stated the schedule was consistent week to week and ULP-C had worked at least 160 hours since the time of hire. CNS-B CNS-B was hired by the licensee on February 1, 2021, to provide supervision of staff and direct care services for residents. CNS-B's employee record lacked documentation of the following required training topics: -initial 2 hours of mental illness and de-escalation training; effective July 1, 2025. ULP-C ULP-C was hired by the licensee on April 1, 2026, to provide direct care services to residents. On July 7, 2026, at 11:50 a.m., the surveyor observed ULP-C assisting R1 with medication administration. ULP-C's employee record lacked documentation of the following required training topics: -initial 8 hours of dementia care training within 160 working hours of the employment start date. -initial 2 hours of mental illness and de-escalation training within 160 working hours of the employment start date; effective July 1, 2025. On July 7, 2026, at 1:43 p.m., CNS-B stated she thought there was only one hour of mental health and de-escalation training required for staff initially, and that was an "oversight on my part." CNS-B further stated all staff would be missing a second hour of the training.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41832	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE HARMONY LLC	135 GERANIUM AVE E SAINT PAUL, MN 55117

(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
01530	Continued From page 25 On July 9, 2026, at 9:30 a.m., owner/licensed assisted living director (O/LALD)-A stated they did not have documentation of the required hours for initial dementia training, and it had been done but was "not tracked very well." O/LALD-A further stated they used a routine schedule that was consistant week to week. The licensee's undated MN ALF Staff Training Compliance Enforcement policy key requirements indicated direct care staff would complete 8 hours of initial dementia and 2 hours of mental illness/de-escalation training before providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41832	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE HARMONY LLC	135 GERANIUM AVE E SAINT PAUL, MN 55117

(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
01700	Continued From page 26 address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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) completed a face-to-face medication management assessment prior to providing medication management services for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or 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: R1 was admitted March 20, 2026, with diagnoses including vascular dementia. R1's signed service plan, dated March 31, 2026, indicated R1 received services including assistance with behavior management, bathing,	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41832	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE HARMONY LLC	135 GERANIUM AVE E SAINT PAUL, MN 55117

(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
01700	Continued From page 27 dressing, grooming, and housekeeping. On July 7, 2026, at 11:50 a.m., the surveyor observed ULP-C assisting R1 with medication administration. R1's medication administration record (MAR) for March 1, 2026, to March 30, 2026, indicated the licensee's staff had assisted R1 with medication administration beginning March 20, 2026. R1's record included a face-to-face medication management assessment dated March 23, 2026, but lacked evidence the RN completed a face-to-face medication assessment prior to providing medication management services. On July 8, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated R1 should have had a medication management assessment done prior to providing services, and it was a lapse in documentation. The licensee's undated Medication Management RN Assessment and Reassessment policy indicated the RN would complete a face-to-face medication management assessment prior to providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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

Food & Beverage Inspection Report

Establishment Info

HILLSIDE HARMONY LLC
135 Geranium Ave S
St Paul, MN 55117
Ramsey County
Parcel:

Phone:
phineas@omniquark.com; bao.vang@athanorhousing.com

License Info

License: HFID 41832

Risk:
License:
Expires on:
CFPM: PHINEAS Y.P. VANG
CFPM #: 64030; Exp: 1/13/2029

Inspection Info

Report Number: F1029261208
Inspection Type: Full - Single
Date: 7/7/2026 Time: 1:30:46 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 5
Total Priority 2 Orders: 5
Total Priority 3 Orders: 7
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG. ILLNESS LOG PROVIDED TO PIC DURING INSPECTION. EMPLOYEE ILLNESS LOGGING, EXCLUSION, AND REPORTING REQUIREMENTS REVIEWED WITH PIC IN ADDITION TO FOODBORNE ILLNESS SYMPTOMS AND THE BIG 5 COMMON FOODBORNE ILLNESS PATHOGENS.

PIC INSTRUCTED TO MAINTAIN THE EMPLOYEE ILLNESS LOG UP-TO-DATE AND PRODUCIBLE UPON REQUEST.

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

! **New Order: 3-100 Food Characteristics: unadulterated**
3-101.11 *Priority Level: Priority 1 CFP#: 13*
MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.
COMMENT: DARK BUILDUP AND GROWTHS ON FOOD CONTAINERS AND IN FOOD BIN IN WALK-IN COOLER. PIC INSTRUCTED TO DISCARD CONTAMINATED ITEMS, CLEAN AND SANITIZE EQUIPMENT, AND BE WATCHFUL FOR SIGNS OF CONTAMINATION AND SPOILAGE.

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

! **New Order: 3-200A Food Characteristics: approved source**
3-201.11A *Priority Level: Priority 1 CFP#: 11*
MN Rule 4626.0130A Remove all foods not obtained from approved sources from the premises.
COMMENT: JARRED BAMBOO SHOOTS OBTAINED FROM A FARMERS' MARKET STORED IN WALK-IN COOLER. JAR WITHOUT ANY IDENTIFYING INFORMATION OTHER THAN A DATE MARK. PIC INSTRUCTED TO REMOVE AND TO ENSURE CANNED, PACKAGED, AND JARRED FOODS/BEVERAGES USED IN THE ESTABLISHMENT'S FOOD SERVICE ARE SOURCED FROM A LICENSED FOOD PROCESSOR.

https://www.health.state.mn.us/communities/environment/food/docs/fs/apprvdsrcefs.pdf

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

New Order: 3-500C Microbial Control: date marking
3-501.17A *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.
COMMENT: COOKED MEATS WITHOUT DATE MARKS. PIC INSTRUCTED TO ENSURE ALL REQUIRED ITEMS ARE DATE MARKED.
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPENED RICED CAULIFLOWER WITHOUT DATE MARK. PIC INSTRUCTED TO DATE MARK ALL REQUIRED ITEMS.
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: OPENED PACKAGE OF RICED CAULIFLOWER AND BAGS OF COOKED MEATS WITHOUT DATE MARKS. EXACT OPEN AND PREPARATION DATES UNKNOWN. PIC INSTRUCTED TO DISCARD ITEMS AND TO DATE MARK REQUIRED ITEMS GOING FORWARD.

https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

! **New Order: 4-100 Equipment Construction Materials**
4-101.11A *Priority Level: Priority 1 CFP#: 47*
MN Rule 4626.0450A Remove all multi-use equipment, utensils, and food storage containers that impart colors, odors, or tastes to food.
COMMENT: INTERIOR COOKING SURFACE MATERIAL OF RICE COOKER/HOLDER SEVERELY DEGRADED, MISSING IN AREAS, AND FLECKING OFF. PIC INSTRUCTED TO REMOVE FROM ESTABLISHMENT.
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 4-100 Equipment Construction Materials
4-101.17 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.
COMMENT: WOOD SPATULA PRESENT. REMOVE.
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 4-100 Equipment Construction Materials
4-101.18 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0493 Discontinue using cleaning aids or utensils that can scratch or scour the nonstick coating of pots, pans, griddles, cookie sheets, waffle makers and other cookware.
COMMENT: NONSTICK POT'S NONSTICK SURFACE DEGRADED AND FLECKING OFF. PIC INSTRUCTED TO REMOVE FROM ESTABLISHMENT AND TO USE UTENSILS AND COOKING METHODS, AND CLEANING AIDS AND CLEANING METHODS THAT DO NOT DAMAGE NONSTICK EQUIPMENT USED IN THE FUTURE.
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 4-200 Equipment Design and Construction
4-202.11 *Priority Level: Priority 2 CFP#: 47*
MN Rule 4626.0515 Discontinue use of multi-use food-contact surfaces that are not smooth, free of breaks, open seams, cracks, chips, pits and other imperfections and that are not accessible for cleaning or inspection.
COMMENT: POROUS CLAY MORTAR PRESENT. PIC INSTRUCTED TO REMOVE.
Comply By: 7/10/2026 Originally Issued On: 7/7/2026

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: CHLORINE TEST STRIPS PRESENT BUT QUAT SANITIZER USED. PIC INSTRUCTED TO OBTAIN AND MAINTAIN QUAT TEST STRIPS ONSITE TO VERIFY 200-400 PPM CONCENTRATIONS.
Comply By: 7/10/2026 Originally Issued On: 7/7/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: BUILDUP OF FOOD DEBRIS AND RESIDUES IN METAL CABINETRY. PIC INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 7/10/2026 Originally Issued On: 7/7/2026

New Order: 4-900 Protecting Clean Items
4-904.11A *Priority Level: Priority 3 CFP#: 45*
MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.
COMMENT: SPOONS STORED BOWL SIDE UP. STORE HANDLE SIDE UP.
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT: WIPING CLOTHS IN HANDWASHING SINK. PIC INSTRUCTED TO ENSURE THINGS ARE NOT PUT INTO HANDWASHING SINKS SO THAT THEY ARE ACCESSIBLE AT ALL TIMES.
Comply By: 7/10/2026 Originally Issued On: 7/7/2026

New Order: 5-500 Refuse and Recyclables
5-501.16C *Priority Level: Priority 3 CFP#: 54*
MN Rule 4626.1255C Provide a waste receptacle at each handwashing sink or group of handwashing sinks if disposable towels are used.
COMMENT: TRASH CANS NOT BY HANDWASHING SINKS IN KITCHEN. PIC INSTRUCTED TO ENSURE ALL HANDWASHING SINKS HAVE WASTE RECEPTACLES PRESENT.
Comply By: 7/10/2026 Originally Issued On: 7/7/2026

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 SIGNS ABSENT AT HANDWASHING SINKS. PIC INSTRUCTED TO ENSURE HANDWASHING SIGNS ARE POSTED AT ALL HANDWASHING SINKS.

https://www.health.state.mn.us/people/handhygiene/wash/fsgermbuster.pdf

https://www.health.state.mn.us/people/handhygiene/wash/dontforget.pdf

https://www.health.state.mn.us/people/handhygiene/wash/hwfactsheet.pdf

Comply By: 7/10/2026 Originally Issued On: 7/7/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: DARK BUILDUP ON WALL NEAR DISHWASHER. SPLATTERING AND BUILDUP ON CEILING AND WALLS. DEBRIS AND RESIDUES UNDER DRY STORAGE RACK. PIC INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 7/10/2026 Originally Issued On: 7/7/2026

Food & Beverage General Comment

Food and beverage inspection conducted as part of HRD survey of ALF.
Surveyor: Tammy Carlson, RN, Nurse Evaluator.
Inspection conducted with Julie Dietz, Consultant, and Phineas Y. P. Vang, CFPM, PIC, Executive Chef.
Foodborne illness risk factors and prevention reviewed. Inspection findings communicated to operators and surveyor.

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 F1029261208 from 7/7/2026

PHINEAS VANG
CFPM PIC

Trevor McCliment

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

HILLSIDE HARMONY LLC
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1029261208
Inspection Type: Full
Date: 7/7/2026
Time: 1:30:46 PM

New Record: Product/Item/Unit: SOUP**; Temperature Process:** Cooling
Location: Walk-in Cooler at 44 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: CUT MELON**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41832015-0	**Date:** July 7, 2026
Facility Name: HILLSIDE HARMONY LLC	
Facility Address: 135 GERANIUM AVE E ST PAUL MN 55117	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Building fire alarm systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

   Comments: The annual inspection and testing for the system was over one year.

3. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: During testing of resident room smoke alarms throughout the facility it was observed that the alarms were over 10 years old from the manufacture date.

4. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: The facility didn't have carbon monoxide alarms in the resident rooms or alarms connected to the fire alarm panel at the source of fuel fire appliances.

5. Water-based automatic sprinkler systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

   Comments: The annual inspection and testing for the wet and dry sprinkler systems was over one year.

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

   Comments: The facility commercial cooking extinguishing system had not been serviced since November 2025.

7. Hoods, grease-removal devices, fans, ducts and other appurtenances shall be inspected at intervals specified in table 607.3.3.1. Inspections shall be completed by qualified individuals. [Minn. Stat. 144G.45 subd. 2; MSFC 607.3.3.1]

   Comments: In the facility kitchen, it was observed that the cooking hood system had not been inspected since December 2024.

8. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: The facility fire alarm panel had a trouble light indicating the battery was missing. The facility had a generator but had not completed the annual inspection and testing.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The evacuation plans lacked accurate identification of resident room numbers and layout. Exit plan diagrams must be correctly labeled to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

2. 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: Licensee lacked documentation showing any evacuation drills occurred. No other information or documentation was provided. The owner/licensed assisted living director (O/LALD)-A, stated they verbally train staff during monthly training.