Electronically Delivered

July 10, 2026

Licensee
Minnesota Group Homes LLC
10355 Grand Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL35663016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

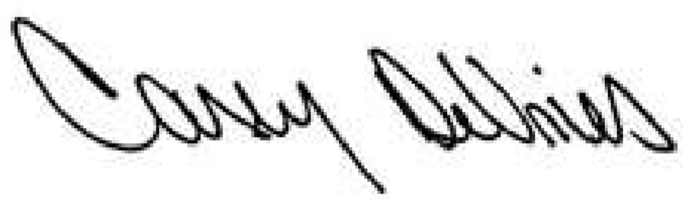
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35663	A. BUILDING: _____ B. WING _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GROUP HOMES LLC	10355 GRAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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: SL35663016-0 On June 1, 2026, through June 4, 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 no residents; none receiving services under the Assisted Living Facility license, therefore, some of the licensee's compliance was determined via closed record review.	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.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a	0 340		

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0 340	Continued From page 1 complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders for a survey completed on June 4, 2024. This had the potential to affect all residents, staff, and visitors at the 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 340		

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0 340	Continued From page 2 or has the potential to affect a large portion or all of the residents). The findings include: On June 3, 2026, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-C stated they did have a plan of correction (POC) to document the actions taken by the facility to comply with the correction orders and that they provided it to a surveyor who did a licensing order follow up survey in 2024, however, they were unable to locate the POC document. The licensee did not provide POC documentation to indicate corrective actions taken related to correction orders previously cited on June 4, 2024. Upon conclusion of the survey initiated on June 1, 2026, the following areas previously cited remained out of compliance: - tag identification number 0550 related to postings of the grievance procedure and contact information for the Office of Ombudsman for Long-Teram Care and Mental Health and Developmental Disabilities; - tag identification number 0680 related to required content of the facility's Emergency Preparedness Plan; and - tag identification number 1290 related to affiliation of staff's background studies with the licensee's health facility identification number. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
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 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 June 2, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=C	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Health Facility Complaints (OHFC), Office of Ombudsman for Long Term Care (OOLTC), and Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD). 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)	0 550		

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0 550	Continued From page 6 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: On June 1, 2026, at 12:10 p.m., during the facility tour, the surveyor observed contact information for the Minnesota Adult Abuse Reporting Center (MAARC), posted on a bulletin board in the living room. The surveyor observed the licensee did not have the following postings: - OHFC contact information; - OOLTC contact information; and - OMHDD contact information. On June 1, 2026, at approximately 12:15 p.m., licensed assisted living director (LALD)-D stated they did have the required contact information posted, but since there was no resident currently residing at the facility, the postings were gone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630		

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0 630	Continued From page 7 taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one discharged resident (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 to the licensee on October 14, 2024, with diagnoses including hypertension, diabetes, post traumatic disorder, and schizoaffective disorder. R1 was discharged from the licensee on September 30, 2024. R1's service plan indicated R1 received assistance with homemaking, shopping, making appointments, socialization, meal preparation, bathing reminders, dressing reminders, medication administration, manage behavior, and manage other mental health needs. R1's IAPP completed on October 15, 2020, indicated R1 was not at risk for sexual abuse and	0 630		

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0 630	Continued From page 8 physical abuse. The IAPP indicated R1 was at risk for self-abuse and also indicated an intervention for self-abuse. R1's IAPP did not contain an individualized review or assessment of R1's risk of abusing other vulnerable adults. On June 3, 2026, at 12:19 p.m., clinical nurse supervisor (CNS)-C stated they did not know how they forgot to include all the required content in R1's IAPP, but they were aware of all the required content for the IAPP. The licensee's Vulnerable Adult Policy, dated January 10, 2025, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided the plan shall contain an individualized assessment of the residents susceptibility to abuse by another individual including other vulnerable adults; the resident's risk of abusing other vulnerable adults and statement of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=A	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650		

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0 650	Continued From page 9 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of four employees (unlicensed personnel (ULP)-B). 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: ULP-B worked for the licensee October 22, 2023, through September 30, 2024, to provide direct care services to residents. The licensee did not have any employee record	0 650		

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0 650	Continued From page 10 available at the facility for ULP-B. On June 2, 2026, at approximately 10:50 a.m., clinical nurse supervisor (CNS)-C stated ULP-B did complete the required training, but they could not find ULP-B's employee records. CNS-C stated all of ULP-B's trainings were on paper and ULP-B did not do their training electronically. On June 2, 2026, at 11:07 a.m., CNS-C again stated they could not find ULP-B's employee record. CNS-C stated, "Nobody moved into this place since 2024, and the documents are all over the place." On June 2, 2026, at 12:35 p.m., via telephone, ULP-B stated they were trained by CNS-C upon hire. ULP-B stated the training was on paper and they did sign their training documents after they completed the training. ULP-B stated they had helped R1 with medication administration, transfers from bed, showers, and meal preparation. On June 2, 2026, at 12:50 p.m., CNS-C provided the surveyor with ULP-B's Serial TB Screening Tools for Health Care Workers document dated June 27, 2023. CNS-C stated the clinic provided the TB document to the licensee via email during the survey. On June 3, 2026, at approximately 12:10 p.m., CNS-C stated they did not know why ULP-B's employee records were missing; ULP-B was trained on how to perform medication administration, how to do personal cares, and all orientation topics. The licensee's Personnel Records Policy dated January 10, 2025, indicated a record of each paid	0 650		

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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
0 650	Continued From page 11 employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living services will be maintained. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: - evidence of current professional licensure, registration or certification; - results of background studies; - records of annual training and infection control training; - documentation of orientation; - documentation of supervision, as applicable; - performance reviews; - competency evaluations; - signed job description; and - documentation of annual performance reviews identifying areas of improvement needed and training needs. Each personnel record shall be maintained for at least three years after an employee, volunteer or contractor ceases to be employed by or under contract with the licensee. The Director/Owner will arrange for safe storage if the agency is closed. There were no residents at the time of the survey and ULP-B was no longer employed by the licensee. 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	0 660		

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	35663	A. BUILDING: _____ B. WING _____	06/04/2026

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0 660	Continued From page 12 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for three of four employees (unlicensed personnel (ULP)-A, registered nurse (RN-E), clinical nurse supervisor (CNS)-C). This had the potential to affect all previous and future residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 13 The findings include: ULP-A ULP-A worked for the licensee November 2, 2020, through September 30, 2024, to provide direct care services to residents. ULP-A's employee record included Baseline TB Screening Tool for Healthcare Workers (HCWs) with a negative QuantiFERON TB gold result completed by another provider where ULP-A was employed, on May 11, 2017. ULP-A's employee record lacked evidence of assessment of current TB disease symptoms, assessment of HCW's history of TB, and TB screening such as TST or blood test, completed upon hire or 90 days prior to hire. R1's MAR dated May 1, 2024, through May 31, 2024, indicated ULP-A administered 8:00 a.m., medication to R1 on the following dates: May 1, 2, 6 ,7, 8, 9, 14, 15, 16, 21, 22, 23, 28, 29, and May 30, 2024. RN-E RN-E was hired on March 6, 2026, to provide oversight to ULPs and to provide direct care services to residents. RN-E's employee record included a negative QuantiFERON TB gold result dated July 26, 2025. RN-E's employee record only contained the blood test results; there was no form to assess the symptoms or history of TB. RN-E's employee record lacked evidence of assessment of current TB disease symptoms, assessment of HCW's history of TB and TB screening such as TST or blood test, completed upon hire or 90 days prior to hire.	0 660		

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0 660	Continued From page 14 CNS-C CNS-C was hired on October 23, 2019, to provide oversight to staff and to provide direct care services to residents. CNS-C's employee record included negative QuantiFERON TB gold results dated July 9, 2020, February 22, 2021, August 28, 2024, and January 15, 2026. CNS-C's employee record only contained the blood test results; there was no form to assess the symptoms or history of TB. CNS-C's employee record lacked evidence of assessment of current TB disease symptoms, assessment of HCW's history of TB, and TB screening such as TST or blood test, completed upon hire or within 90 days prior to hire. On June 3, 2026, at 12:07 p.m., CNS-C stated they did QuantiFERON TB Gold and TB risk assessment "We do TB gold test and there is bunch of questions that we ask." The surveyor asked if they had TB history and risk assessment form completed for the above-mentioned employees. CNS-C stated if it was not in the employee records then it was not there. On June 3, 2026, at 12:30 p.m., CNS-C stated they did the TB screening for employees before the employees started working with residents. CNS-C they did honor employee's TB results completed before hire. CNS-C stated they did not know that employees were required to have TB screening such as TST or blood test, completed upon hire or within 90 days prior to hire, CNS-C stated, they thought if the employees presented a prior TB screening it would be good enough. Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated	0 660		

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0 660	Continued From page 15 baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The Licensee's Tuberculosis Screening/Prevention Policy dated January 10, 2025, indicated the licensee will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MOH). The precautions include the following elements: - Risk Assessment - TB Screening - Staff Education No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 16 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 interview and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all future residents under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 680		

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0 680	Continued From page 17 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked the following required content: - quarterly review of missing residents policy; - yearly review of the EPP; - hazard vulnerability assessment; - EP program patient population; - process for EP collaboration; - policies and procedures for sheltering; - policies and procedures for medical documents; - role under a waiver declared by secretary; - development of communication plan; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - LTC family notification; - procedure for tracking of staff and residents; - policies and procedures for volunteers; - arrangements with other facilities; and - subsistence needs for staff and residents including emergency lighting. On June 3, 2026, at 11:25 a.m., licensed assisted living director (LALD)-D stated the EPP that they provided the surveyor was the old plan and they stated the new one was saved in the computer. LALD-D stated they would print and provide it to the surveyor. On June 3, 2026, at 11:51 a.m., LALD-D stated they did not print the EPP because it was a big file. The surveyor requested LALD-D provide the file via email. On June 3, 2026, at 1:35 p.m., LALD-D stated the missing resident plan was reviewed anytime there	0 680		

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0 680	Continued From page 18 was a change. On June 3, 2026, at 8:26 p.m., via email, LALD-D provided a fire safety and evacuation plan. On June 4, 2026, via telephone during the exit conference LALD-D stated the above-mentioned Fire Safety and Evacuation Plan was what they had for their EPP. The licensee's Missing Resident policy dated January 10, 2025, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly. Changes to the plan will be documented. The licensee's Emergency Management Policy dated January 10, 2025, indicated the licensee will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. The emergency preparedness plan/program will be reviewed/updated at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=A	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	0 730		

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0 730	Continued From page 19 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 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.	0 730		

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0 730	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide service administration documentation for one of one discharged resident (R1). 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: R1 was admitted to the licensee on October 14, 2020, with diagnoses including hypertension, diabetes, post traumatic disorder and schizoaffective disorder. R1 was discharged on September 30, 2024. R1's Service Plan indicated R1 received assistance with homemaking, shopping, making appointments, socialization, meal preparation, bathing reminders, dressing reminders, medication administration, manage behavior and manage other mental health needs. R1's medication administration record (MAR) indicated ULP-B administered 8:00 a.m., medication to R1 on the following dates: September 18, 19, and September 23, through 29, 2024. R1's record lacked documentation for service administration to show R1 was receiving the additional above-mentioned services.	0 730		

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0 730	Continued From page 21 On June 2, 2026, at 10:51 a.m., clinical nurse supervisor (CNS)-C stated they were unable to locate R1's service documentation. CNS-C stated they lost the key to the medication cabinet, and they believed the service documentation was in the cabinet. On June 2, 2026, at 11:07 a.m., CNS-C stated they found the key to the cabinet, but they did not find R1's service documentation record. CNS-C stated, "Nobody moved into this place since 2024, and the documents are all over the place." On June 3, 2026, at 1:00 p.m., CNS-C stated R1's whole file was missing for R1's service charting and the CNS was still unable to find it. The licensee's Clinical Records policy dated January 10, 2025, indicated a clinical record will be started for each resident on admission to the assisted living. The policy indicated the clinical record contains documentation of services provided as identified in the service plan. Following the resident's discharge or termination of services, the licensee will retain the clinical record for at least five years or otherwise required by state or federal regulation. There were no residents at the time of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 22 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; 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	0 780		

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0 780	Continued From page 23 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 June 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 24 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota	0 810		

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0 810	Continued From page 25 Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=A	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 contract with the required content for one of one discharged resident. 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: R1's Assisted Living contract signed on July 8,	0 910		

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	35663	A. BUILDING: _____ B. WING _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GROUP HOMES LLC	10355 GRAND AVENUE SOUTH BLOOMINGTON, MN 55420

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0 910	Continued From page 26 2024, had the licensee's sister facility's physical mailing address and lacked the correct physical mailing address of the licensee's facility. The contract also lacked the resident's name. On June 3, 2026, at 11:17 a.m., licensed assisted living director (LALD)-D stated the physical mailing address listed was the wrong address and it was the licensee's sister facility address. LALD-D stated the resident did not reside at the address listed on the contract, R1 resided at the licensee's facility; the wrong address was an oversight and the resident's name was also not written on the contract due to oversight. There were no residents at the time of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;	0 930		

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0 930	Continued From page 27 (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; 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 all required content for one of one discharged resident (R1). This practice resulted in a level one violation (a violation that has no 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: R1's Assisted Living contract signed on July 8, 2024, lacked the right under section 144G.54 to appeal termination of an assisted living contract. On June 3, 2026, at 11:20 a.m., licensed assisted living director (LALD)-D stated they were not aware they were missing the above-mentioned content from the contract. There were no residents at the time of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 930		

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0 930	Continued From page 28 (21) days	0 930		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and	01060		

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01060	Continued From page 29 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one discharged resident (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 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: R1 was admitted to the licensee on October 14, 2024, with diagnoses including hypertension, diabetes, post traumatic disorder, and schizoaffective disorder. R1's service plan indicated R1 received assistance with homemaking, shopping, making appointments, socialization, meal preparation, bathing reminders, dressing reminders, medication administration, manage behavior, and manage other mental health needs. R1's progress notes written on August 25, 2024,	01060		

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01060	Continued From page 30 indicated on August 18, 2024, R1 was brought to the emergency room due to low grade fever and R1 was admitted to the hospital. R1 was discharged from the hospital on August 25, 2024. R1's record lacked evidence a written notice was provided that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal; and - a notice to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On June 3, 2026, at 9:30 a.m., clinical nurse supervisor (CNS)-C stated they did not provide emergency relocation form to R1 or R1's family, and they did not send a notification to the office of Ombudsman for Long-Term Care. CNS-C further stated they were not aware of the requirement to provide emergency relocation forms and a notification to the office of Ombudsman for Long-Term Care. The licensee's Discharge and Transfer of Residents policy dated January 10, 2025,	01060		

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01060	Continued From page 31 indicated in the event and emergency relocation, the facility will provide written notice emergency relocation to the following as soon as possible: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to the licensee within four (4) days, the Office of Ombudsman for Long-Term Care f. Notice of the right to appeal the decision under 144G.54 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	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 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for three of seven employees who worked with a former resident of the licensee's facility (unlicensed personnel (ULP)-B, ULP-A, housekeeping (HK)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B worked for the licensee from August 8, 2023, through September 30, 2024, to provide direct care and services to residents. R1's medication administration record (MAR) indicated ULP-B administered 8:00 a.m., medication to R1 on the following dates: September 18, 19, and September 23, through 29, 2024. The licensee's NETStudy 2.0 roster (web-based system used to submit background study requests to the Department of Human Services (DHS)) did not include ULP-B in the list of employees whose BGS were affiliated with the licensee's healthcare facility identification (HFID)	01290		

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01290	Continued From page 33 35663. A screenshot taken from the DHS website on June 2, 2026, at approximately 12:20 p.m., indicated ULP-B was separated from the licensee's HFID 35663 on July 12 and July 27, 2023. A DHS background study notice dated July 12, 2023, and July 27, 2023, indicated ULP-B did not provide fingerprints and photo in the time required and they must be removed from their position immediately. On June 2, 2026, at approximately 12:30 p.m., via telephone ULP-B confirmed that they worked for the licensee when the licensee had a resident and they quit working for the licensee when R1 passed away. ULP-B stated they helped R1 with medication administration, bathing, and meal preparation. On June 2, 2026, at 12:53p.m., licensed assisted living director (LALD)-D stated they did not run the BGS for ULP-B. LALD-D stated they thought they ran it the same day ULP-B applied, and the same day the TB test was done, but they realized they did not do the BGS. LALD-D stated they could not find anything on NETStudy, "I thought I did the BGS, but it slipped away from me." On June 2, 2026, at 1:01p.m., LALD provided the surveyor with the copy of the DHS letter mentioned above dated July 27, 2023, and stated, "I did run the BGS in July, sorry". The surveyor then read the letter to LALD-D and asked why they hired ULP-B instead of removing ULP-B as per the instructions on the letter. LALD-D stated they did not even read the letter and said, "I am sorry". LALD-D stated they did not	01290		

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01290	Continued From page 34 even go back and check if fingerprints were required because during COVID, DHS did not require finger printing. ULP-A ULP-A worked for the licensee November 2, 2020, through September 30, 2024, to provide direct care and services to residents. R1's MAR dated May1, 2024, through May 31, 2024, indicated ULP-A administered 8:00 a.m., medication to R1 on the following dates: May 1, 2, 6 ,7, 8, 9, 14, 15, 16, 21, 22, 23, 28, 29, and May 30, 2024. The licensee sister facility included ULP-A in the list of employees whose BGS were affiliated to HFID 35073. However, the licensee's NETStudy 2.0 roster did not include ULP-A on the list of employees whose BGS were affiliated with the licensee's HFID 35663. The licensee failed to affiliate ULP-A's BGS the licensee's HFID 35663. HK-F HK-F worked for the licensee July 7, 2020, through August 23, 2021, and was rehired and worked for the licensee March 1, 2024, through September 30, 2024, to provide housekeeping services to residents. The licensee's NETStudy 2.0 roster did not include HK-F in the list of employees whose BGS were affiliated to the licensee's HFID 35663. The licensee's sister facility NETStudy 2.0 roster under HFID 35073 indicated HK-F's eligibility-Covid-19 study expired on December 31, 2022. On June 2, 2026, at 1:15 p.m., LALD-D stated	01290		

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01290	Continued From page 35 they did not know they had to affiliate employees BGS to each facility; LALD-D stated they thought running the BGS was good enough. LALD-D stated they did not know HF-K had to do finger printing and the Covid -19 study had expired. ON June 3, 2026, at 1:03 p.m., clinical nurse supervisor (CNS)-C stated ULP-A, ULP-B, and HF-K worked with residents unsupervised. The licensee's Background Studies policy dated February 1, 2024, indicated no employee may provide direct services and have independent direct contact with any residents until acceptable results of the background study have been received. The licensee will not employ individuals whose results of the background study indicate disqualification for the position. On September 3, 2025, the Minnesota Department of Human Services website indicated the following: - Emergency studies completed during the COVID-19 pandemic were no longer valid. - Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their	01290		

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01290	Continued From page 36 rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. There were no residents at the time of the survey, and the above-mentioned staff were no longer employed by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01290		
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	01530		

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01530	Continued From page 37 eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two current employees (registered nurse (RN)-E, clinical nurse supervisor (CNS)-C) received at least two hours of initial mental illness training. 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	01530		

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01530	Continued From page 38 has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-E RN-E was hired on March 6, 2026, to provide oversight to ULPs and to provide direct care services to residents. RN-E's employee record included an Educare (training software) transcript which indicated RN-E had completed 1.5 hours of mental illness training on May 27, 2026. RN-E's employee record lacked 0.5 hours of the required initial mental illness training. CNS-C CNS-C was hired on October 23, 2019, to provide oversight to staff and to provide direct care services to residents. CNS-C's employee record included an Educare transcript which indicated CNS-C had completed 0.75 hours of mental illness training on December 20, 2024. RN-E's employee record lacked 1.25 hours of the required initial mental illness training. On June 3, 2026, at approximately 12:25 p.m., CNS-C stated they did not remember how many hours of initial mental illness training was required but they usually followed a checklist and stated they did not know how it got missed. The licensee's Education on Mental Illness and De-escalation policy dated January 10, 2025, indicated Dementia Care Training policy indicated supervisors of direct-care staff will have at least two (2) hours of initial education within 120 working hours of employment start date in the	01530		

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	35663	A. BUILDING: _____ B. WING _____	06/04/2026

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MINNESOTA GROUP HOMES LLC	10355 GRAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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 39 following topics: a. recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; b. de-escalation techniques and communication; and c. crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 interview and record review, the licensee failed to maintain current medication orders for one of one discharged resident (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 a widespread scope (when	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 40 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: R1 was admitted to the licensee on October 14, 2024, with diagnoses including hypertension, diabetes, post traumatic disorder, and schizoaffective disorder. R1 discharged from the licensee on September 30, 2024. R1's service plan indicated R1 received assistance with homemaking, shopping, making appointments, socialization, meal preparation, bathing reminders, dressing reminders, medication administration, manage behavior, and manage other mental health needs. R1's MAR dated May1, 2024, through May 31, 2024, indicated ULP-A administered 8:00 a.m., medication to R1 on the following dates: May 1, 2, 6 ,7, 8, 9, 14, 15, 16, 21, 22, 23, 28, 29, and May 30, 2024. R1's record lacked signed physician orders. On June 3, 2026, at 10:27 a.m., clinical nurse supervisor (CNS)-C stated they looked through R1's file and they were unable to locate signed physician orders for R1. CNS-C stated they believed they provided a signed physician order to the surveyor in 2024. The surveyor reviewed evidence collected from the June 2024 survey and found an after-visit summary (AVS) for R1 dated April 25, 2024, signed by Doctor of Pharmacy (Pharm.D.). On June 3, 2026, at 10:30 a.m., CNS-C provided	01820		

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01820	Continued From page 41 the surveyor with the above-mentioned AVS and stated it was the signed order. The surveyor asked CNS-C if the AVS was signed by a physician. CNS-C pointed to the signature signed by Pharma. D. The surveyor explained that it was a pharmacist's signature. CNS-C then stated it was a pharmacist's signature for medication reconciliation, and confirmed the document was not signed by R1's provider. The licensee's Prescriber's Orders Policy dated January 10, 2025, indicated all medication orders must be signed and dated by the prescriber, medication and treatment orders would be renewed at least every year or when changes occur. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one discharged resident (R1) with hospital bed rails.	02310		

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02310	Continued From page 42 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 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 to the licensee on October 14, 2020, with diagnoses including hypertension, diabetes, post traumatic disorder, and schizoaffective disorder. R1 was discharged on September 30, 2024. R1's Service Plan indicated R1 received assistance with homemaking, shopping, making appointments, socialization, meal preparation, bathing reminders, dressing reminders, medication administration, manage behavior, and manage other mental health needs. R1's record included a Side-Rail (bed rail) Use Assessment Form dated December 20, 2020. The form indicated R1 had bilateral side rails with zone measurements, side rail use assessment, and risk and benefit form. R1's record did not include evidence the licensee completed a bed rail reassessment every 90 days. On June 3, 2026, at approximately 12:45 p.m., clinical nurse supervisor (CNS)-C sated R1 had a hospital bed with bed rails while they resided in the licensee's facility. CNS-C stated they did bed rail assessment every 90 days. The surveyor observed CNS-C go through R1's file and CNS-C stated they only saw one assessment completed for R1; re-assessment was not done for R1 and	02310		

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02310	Continued From page 43 stated they did not know how they missed the 90-day bed rail assessments. On June 3, 2026, at 1:15 p.m., CNS-C stated R1 had a bed rail when they were admitted, then R1's family requested not to use bed rails and to use a normal bed, therefore when a survey was conducted in 2024, R1 was not using bed rails. CNS-C stated during R1's last few months of life before R1 passed away in the hospital, R1 again used bed rails. CNS-C stated they forgot to redo the bed rail assessment at that time. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." Additionally, the FAQ indicated documentation of a bed rail should include but is not limited to: - purpose and intention of the bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated	02310		

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02310	Continued From page 44 risk agreements. The licensee's Side Rail Use Policy dated January 10, 2025, indicated before implementing side rails for a resident the RN will conduct side rail assessment to determine if the resident is safe to use the side rails. The need for side rails will be reassessed, and the side rails will be inspected as needed but not less than every 90 days. There were no residents at the time of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

MINNESOTA GROUP HOMES LLC
10355 GRAND AVENUE SOUTH
Bloomington, MN 55420
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35663

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1018261095
Inspection Type: Full - Single
Date: 6/2/2026 Time: 8:32:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: Establishment does not currently have a Certified Food Protection Manager on site. Discussed the application process with staff.
Comply By: 6/2/2026 Originally Issued On: 6/2/2026

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: Kitchen observed with heavy debris build up on the floors and walls, and on the surfaces of equipment. Discussed cleaning these areas with staff.
Comply By: 6/2/2026 Originally Issued On: 6/2/2026

Food & Beverage General Comment

Inspection completed with Dee Mosissa (MDH)

Establishment is a residential home with residential equipment.

The establishment does all same day service of foods.

Kitchen has a dishwasher with sanitize function available.

Kitchen has a two basin sinks with sides delegated for hand washing and food prep.

Equipment was observed to be in good condition.

Floors are tiles, walls are painted and ceiling is smooth painted. All in good condition.

Cabinets are painted wood, and in good condition.

Establishment has a thermometer for checking food temperatures.

Discussed employee illness and pest control. Viewed illness log.

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 F1018261095 from 6/2/2026

Rebecca Prestwood

Bashir Geelle
Manager

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

MINNESOTA GROUP HOMES LLC
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1018261095
Inspection Type: Full
Date: 6/2/2026
Time: 8:32:15 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL35663016-0	**Date:** 6/3/2026
Facility Name: MINNESOTA GROUP HOMES LLC	
Facility Address: 10355 GRAND AVENUE SOUTH BLOOMINGTON MN	

☒ **TAG IDENTIFICATION: 0780**

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

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

   Comments: Two separate smoke alarm systems were installed, a hardwired system and a wireless alarm, but each separate system was not interconnected. The hardwired smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms.

☒ **TAG IDENTIFICATION: 0810**

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

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

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

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

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