DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

May 14, 2026

Licensee
Grove Living Company
7248 Bancroft Way
Inver Grove Heights, MN 55077

RE: Provisional Conditional License Number 419567
Health Facility Identification Number (HFID) 40982
Project Number(s) SL40982015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 24, 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 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 13, 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 . . ."

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 $1,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0480 - 144g.41 Subdivision 1 Subd. 1a (a-B) - Minimum Requirements; Required Food Services S-S= F
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 1330 - 144g.60 Subd. 4 (b) - Unlicensed Personnel S-S= E
St - 0 - 1530 - 144g.64 (a) (1-2) - Training In Dementia, Mental Illness, And De- S-S= D
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring S-S= F

St - 0 - 1700 - 144g.71 Subd. 2 - Provision Of Medication Management Services S-S= F
St - 0 - 1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan S-S= F

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 Grove Living Company a conditional provisional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 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 Grove Living Company is in substantial compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** Grove Living Company will not admit any new residents under its conditional provisional assisted living facility license until MDH

removes the “no new admissions” condition. Grove Living Company must provide the Department:

i. A list of the names and birthdates of any individuals Grove Living Company 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

c. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Grove Living Company to correct the violations cited during the survey as well as to determine the overall practice of Grove Living Company in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.

e. **Corrective Action Plan:** Grove Living Company will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Grove Living Company is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines Grove Living Company is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Grove Living

Company. If MDH determines Grove Living Company 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 Stephanie Jones de Palma directly at: 651-201-4320 or email at: stephanie.jones.de.palma@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40982	A. BUILDING: _____ B. WING _____	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE LIVING COMPANY	7248 BANCROFT WAY INVER GROVE HEIGHTS, MN 55077

(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: SL40982015-0 On March 23, 2026, through March 24, 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 was one resident; one resident receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 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 1 (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, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 24, 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 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (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.	0 810		

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0 810	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 24, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		
01330 SS=E	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs	01330		

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01330	Continued From page 5 (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competency training and evaluations were completed for two employees (owner/unlicensed personnel (O/ULP)-A, assisted living director in residency (ALDIR)-B) prior to providing direct care. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: O/ULP-A O/ULP-A had a hire date of April 26, 2025, to provide personal care to the licensee's residents. On March 24, 2026, at 8:30 a.m., the surveyor observed O/ULP-A set up and administer R1's	01330		

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01330	Continued From page 6 medications and check R1's blood sugar. O/ULP-A's training record lacked the following required competencies prior to providing services: - appropriate and safe techniques in personal hygiene and grooming including hair care and bathing, care of teeth, bums and oral prosthetic devices, care and use of hearing aids, dressing and assistance with toileting. In addition, O/ULP-A's training record indicated he was assigned "understanding appropriate boundaries between staff and residents and the resident's family" training; however, he had not completed it. On March 23, 2026, at 2:50 p.m., O/ULP-A stated he had completed the above listed training topics through Relias (an online training program) and thought the nurse had completed competency training on all the required tasks; however, he could not find evidence it was done. He further stated he missed the assigned boundaries training and would complete it immediately. ALDIR/ULP-B ALDIR/ULP-B had a hire date of April 28, 2025, to provide personal care to the licensee's residents. On March 23, 2026, at 2:00 p.m., O/ULP-A stated ALDIR-B worked the evening/overnight shift to provide cares/services to the licensee's one current resident. ALDIR/ULP-B's training record lacked the following required topics prior to providing services: -documentation requirements for all services provided; and -reports of changes in the resident's condition to	01330		

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01330	Continued From page 7 the supervisor designated by the assisted living provider On March 23, 2026, at 2:00 p.m., O/ULP-A stated ALDIR/ULP-B had been assigned the above listed trainings; however, he had not completed them as assigned. The licensee's Competency Training Evaluations policy dated March 26, 2025, indicated a registered nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. Training and competency evaluations for all ULPs will include: - Documentation requirements for all services provided; - Reports of changes in the resident's condition to the supervisor designated by the facility; - 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 iv. dressing and assisting with toileting; and - Understanding appropriate boundaries between staff and residents and the resident's family No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530		

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01530	Continued From page 8 (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 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;	01530		

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01530	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (assisted living director in residency/unlicensed personnel (ALDIR/ULP)-B) received the required amount of dementia care training in the required time frame. 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: The licensee held a provisional assisted living facility license (PALF). ALDIR/ULP-B had a hire date of April 28, 2025, to provide personal care to the licensee's residents. On March 23, 2026, at 2:00 p.m., owner/unlicensed personnel (O/ULP)-A stated ALDIR/ULP-B worked the evening/overnight shift to provide cares/services to the licensee's one current resident. ALDIR/ULP-B's employee record included an Educare training transcript (the licensee's online training program), printed March 23, 2026, and indicated ALDIR/ULP-B completed 6.75 hours of dementia related training; however, lacked the	01530		

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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
01530	Continued From page 10 required eight hours of dementia related training. On March 23, 2026, at 2:00 p.m., O/ULP-A stated ALDIR/ULP-B had been assigned the required eight hours of dementia training through Educare; however, ALDIR/ULP-B had completed all but 1.25 hours and stated no further evidence of dementia-related training was found. O/ULP-A stated ALDIR/ULP-B had worked greater than 160 hours since being hired. The licensee's Dementia Training policy dated March 26, 2025, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the start date. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40982	A. BUILDING: _____ B. WING _____	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE LIVING COMPANY	7248 BANCROFT WAY INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 11 distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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	40982	A. BUILDING: _____ B. WING _____	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 12 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days from the previous assessment for the licensee's one resident (R1). Furthermore, the licensee failed to complete an assessment for safe smoking for the licensee's one 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: 90 DAY ASSESSMENTS R1 began receiving services from the licensee on June 1, 2025, with diagnoses including type 2 diabetes, schizophrenia, and anxiety. R1's Service Plan dated June 13, 2025, included the services of medication administration, blood sugar checks, and assistance with dressing, bathing, and grooming. On March 24, 2026, at 8:30 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A set up and administer R1's medications and check R1's blood sugar. R1's record included RN Assessments dated June 2, 2025, September 2, 2025, and December 14, 2025.	01620		

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	40982	A. BUILDING: _____ B. WING _____	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE LIVING COMPANY	7248 BANCROFT WAY INVER GROVE HEIGHTS, MN 55077

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01620	Continued From page 13 R1's assessments dated September 2, 2025, and December 14, 2025, were completed 103 days apart. Furthermore, R1's record lacked an RN Assessment since December 14, 2025, (due March 14, 2026), and at the time of survey was 10 days late. The licensee failed to ensure comprehensive assessments were completed at least every 90 days as required. SMOKING ASSESSMENT On March 23, 2026, at 11:45 a.m. during a facility tour with O/ULP-A, the surveyor observed a ceramic type of plant pot on the back patio. O/ULP-A stated R1 smoked independently outside on the back patio and used the ceramic pot for cigarette disposal. O/ULP-A further stated they were working with R1's doctor on a smoking cessation plan. R1's RN Assessments as dated above lacked an assessment of R1's smoking safety. On March 24, 2026, at 10:00 a.m., clinical nurse supervisor (CNS)-C stated she was late with the most recent RN assessment and further stated she believed she had completed a paper version smoking assessment since the licensee's electronic medical record system used did not include a smoking assessment; however, CNS-C and O/ULP-A could not find any record of a completed smoking assessment. CNS-C completed R1's 90-day assessment during the time of survey. The licensee's Assessments, Reviews, and Monitoring policy dated March 26, 2025, indicated the initial nursing assessment or reassessment must include all the elements of the uniform	01620		

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01620	Continued From page 14 assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. Resident reassessment. Additionally, monitoring must be conducted no more than 14 calendar days after initiating services, on-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
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 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	01700		

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01700	Continued From page 15 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) conducted a face-to-face medication management assessment to include all required content for the licensee's one resident (R1) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 23, 2026, at 11:00 a.m., owner/unlicensed personnel (O/ULP)-A confirmed the licensee provided medication management services to all the residents receiving assisted living services. R1 began receiving services from the licensee on June 1, 2025, with diagnoses including type 2 diabetes, schizophrenia, and anxiety.	01700		

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01700	Continued From page 16 R1's Service Plan dated June 13, 2025, included the services of medication administration. On March 24, 2026, at 8:30 a.m., the surveyor observed O/ULP-A set up and administer R1's medications and check R1's blood sugar. R1's Medication Administration Record (MAR) dated March 2026, included two medications for diabetes, one for cholesterol, two for agitation, one for prostate, one for depression, and one for mild pain. R1's Medication Assessment as found in R1's comprehensive RN assessments dated June 2, 2025, September 2, 2025, and December 14, 2025, indicated R1 needed assistance with medication administration; however, it lacked evidence the assessment was conducted face-to-face with the resident. The assessment did not include an identification and review of all medications the resident was known to be taking, to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. Furthermore, the assessment did not identify interventions needed in management of medications to prevent diversion of medication by the residents 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. On March 24, 2026, at 10:05 a.m., clinical nurse supervisor (CNS)-C stated the electronic medical record system (EMR) the licensee used did not include a medication assessment with all the required content and she believed she completed	01700		

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01700	Continued From page 17 a medication assessment at the time of R1's admission by using a paper copy/template. CNS-C and O/ULP-A could not locate the paper copy of R1's Medication Assessment. The licensee's Medication Management-Assessment, Monitoring and Reassessment policy dated March 26, 2025, indicated [licensee name] will prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. 1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) 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. ** "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 19 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for the licensee's one 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 began receiving services from the licensee on June 1, 2025, with diagnoses including type 2 diabetes, schizophrenia, and anxiety. R1's Service Plan dated June 13, 2025, included the services of medication administration. On March 24, 2026, at 8:30 a.m., the surveyor observed O/ULP-A set up and administer R1's medications and check R1's blood sugar. R1's Medication Administration Record (MAR)	01730		

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01730	Continued From page 20 dated March 2026, included two medications for diabetes, one for cholesterol, two for agitation, one for prostate, one for depression, and one for mild pain. R1's assessments dated September 2, 2025, and December 14, 2025, included a section labeled, "Medication Management "and included the following: Staff will administer all prescribed and over the counter medications according to the physician's orders and document each administration in the medication log. Staff will monitor the side effects, ensure medications are taken on time, and report any concerns to the healthcare provider. R1's record lacked a medication plan to include the following elements as required: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - identification of medication management tasks that may be delegated to unlicensed personnel; On March 24, 2026, at 10:10 a.m. clinical nurse supervisor (CNS)-C stated she was certain she completed a paper copy of a medication plan that included the required content at the time of R1's admission; however, she was unable to locate it. The licensee's Medication Management Individualized Plan policy dated March 26, 2025, indicated the licensee would develop a	01730		

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01730	Continued From page 21 medication plan to include; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - identification of medication management tasks that may be delegated to unlicensed personnel No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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

Grove Living Company
7248 Bancroft Way
Inver Grove Heights, MN 55077
Dakota County
Parcel:

Phone: 6126167795

License Info

License: HFID 40982
Korsso Tufa
Risk:
License:
Expires on:
CFPM: Korsoo D. Tufa
CFPM #: CFPM-57388; Exp: 04/04/2028

Inspection Info

Report Number: F1005261090
Inspection Type: Full - Single
Date: 3/24/2026 Time: 10:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: THE FOOD THERMOMETER ON SITE WOULD NOT TURN ON. REPAIR OR REPLACE THERMOMETER.
Comply By: 3/31/2026 Originally Issued On: 3/24/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: THERE WAS NO INDICATOR ON SITE TO TEST THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. PROVIDE DISPOSABLE TEMPERATURE STRIPS OR A MAXIMUM REGISTERIN THERMOMETER TO ENSURE THE DISH MACHINE IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

Comply By: 3/31/2026 Originally Issued On: 3/24/2026

Food & Beverage General Comment

INSPECTION COMPLETED WITH PERSON IN CHARGE AND REVIEWED WITH HRD NURSING EVALUATOR DEBORAH JACOBSON.

THERMOLABELS WERE LEFT ON SITE FOR OPERATOR TO TEST DISHWASHER. OPERATOR SENT INSPECTOR A PICTURE OF THE LABEL AFTER RUNNING IT THROUGH THE DISHWASHER, SHOWING IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS WOOD AND CABINETS ARE WOOD WITH HOLLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005261090 from 3/24/2026

KORSSO TUFA
PIC

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL40982015-0	**Date:** 3/24/2026
Facility Name: Grove Living Company	
Facility Address: 7248 Bancroft Way, Inver Grove Heights, Minnesota 55077	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The posted evacuation floor plans indicated the garage was a designated exit. Exiting through an area of higher hazard is not allowed.

   The posted evacuation plans did not define the exit routes throughout the 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: Owner/unlicensed personal (O/ULP)-A stated no resident policy was in place at this time.

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

   Comments: O/ULP-A stated no unique and unusual needs policy was created for the residents of the facility.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: O/ULP-A stated only one staff training was completed on 6-1-25. No additional training documentation was provided.

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

   Comments: O/ULP-A stated no resident training was offered or provided since the facility started providing services.