Electronically Delivered

June 16, 2026

Licensee
Healing Home Services LLC
6051 4th Street Northeast
Fridley, MN 55432

RE: Project Number(s) SL36747016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 13, 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.

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:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36747	A. BUILDING: _____ B. WING _____	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOME SERVICES LLC	6051 4TH ST NE FRIDLEY, MN 55432

(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: SL36747016-0 On May 11, 2026, through May 13, 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 three (3) residents; all received services under the Assisted Living Facility license. On May 12, 2026, an immediate correction order was issued for tag identification 1290. During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope and level remained unchanged.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staffing schedule was posted with the required content as indicated in Minnesota Administrative Rule 4659.0180. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470		

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0 470	Continued From page 2 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: The licensee held an Assisted Living license for a bed capacity of four (4) residents. At the time of the survey, there were three (3) residents; all received services under the Assisted Living Facility license. On May 11, 2026, at 10:18 a.m., the surveyor entered the facility and was greeted by unlicensed personnel (ULP)-B who was working at the time. During entrance conference on May 11, 2026, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the staff schedule included 8-hour shifts and 12-hour shifts depending on the day of the week and one ULP was scheduled for each shift. During observation on May 11, 2026, at 11:32 a.m., the surveyor was unable to locate the licensee's daily staff schedule. LALD/CNS-A stated the daily staffing schedule was normally posted in the living room next to the calendar, but she was unable to locate it. At 12:45 p.m., LALD/CNS-A provided a monthly "October" staff schedule which included staff names for each shift and day of the week and the licensee's previous facility address. On May 12, 2026, at 9:38 a.m., the surveyor observed the licensee had posted the October	0 470		

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0 470	Continued From page 3 staff schedule on the wall next to the calendar. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., the clinical nurse supervisor (CNS) must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily staffing schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The licensee's Staffing policy dated February 24, 2022, noted the 24-hour daily staffing schedule must be posted at the beginning of the shift in a central location accessible to staff, residents, volunteers, and the public and must include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	0 480		

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0 480	Continued From page 4 (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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	0 480		

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0 480	Continued From page 5 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 May 11, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 680	Continued From page 6	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency preparedness plan (EPP) prominently, and post emergency exit diagrams on each floor. Further, the licensee failed to develop an EPP with all of the required content tailored to the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 7 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: During posting review on May 11, 2026, at 11:27 a.m., the surveyor was unable to locate posted emergency exit diagrams on either floor (facility was a one level rambler with a lower level) or locate the EPP. On May 11, 2026, at 11:32 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the EPP was kept downstairs and would bring it up during staff meetings. On May 11, 2026, at 12:45 p.m., LALD/CNS-A stated the emergency exit diagrams were not posted on either floor. The licensee's EPP last reviewed on October 1, 2025, was only partially tailored to the facility's needs and lacked evidence of the following required information: - missing resident plan updated quarterly; - must identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - develop/implement EPP policies and procedures (P/P) to address the following whether evacuated or shelter in place for staff/residents (not tailored to facility as it contained information that did not apply and one policy included an unrelated licensee's name);	0 680		

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0 680	Continued From page 8 - communication plan must include: - names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - contact information for state, tribal, regional and local emergency preparedness (EP) staff; - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. Must include the following: - participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On May 12, 2026, at 11:40 a.m., house manager (HM)-E stated he conducted fire and tornado drills with staff and would complete scenario-based drills but did not document those exercises. On May 13, 2026, at 12:17 p.m., LALD/CNS-A stated she was responsible for maintaining the EPP and said it was not displayed prominently as required and thought the missing resident plan needed to be reviewed annually. LALD/CNS-A also acknowledged the emergency testing exercises were not documented. At 12:45 p.m., LALD/CNS-A stated regarding missing EPP content, she provided another binder which was a	0 680		

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0 680	Continued From page 9 new template that had not been modified yet and stated owner/administrator (O/A)-D had made updates to the EPP and began looking at her email for the updates. They were not provided by survey completion. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. The licensee's Emergency Preparedness policy dated February 24, 2026, indicated the emergency disaster plan would be prominently posted on each floor of the facility and have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated February 24, 2022, indicated the director and CNS would review the missing resident procedure at least quarterly and changes to the plan would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 10 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 May 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=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	0 810		

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0 810	Continued From page 11 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 810		

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	36747	A. BUILDING: _____ B. WING _____	05/13/2026

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0 810	Continued From page 12 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 May 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 910		

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0 910	Continued From page 13 licensee failed to execute a written contract with the required content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had relocated from the previous facility location in Minneapolis to the current facility in Fridley during the month of August 2025. The licensee's Current Client Roster: Comprehensive (144A) printed May 11, 2026, indicated R2 and R3's start of services were August 27, 2024, and September 3, 2024, respectively. On May 12, 2026, at 3:50 p.m., the surveyor asked for clarification on admission dates for all residents because dates in medical records did not match dates on the current roster. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided the admission dates as follows: -R2 was admitted on June 12, 2023; and -R3 was admitted on February 6, 2023. R2 R2's [Licensee] Resident Contract for Assisted Living signed on June 12, 2024, indicated R2's occupancy date was June 12, 2022, and the facility address and address for assisted living licensee was 1073 26th Avenue SE Minneapolis,	0 910		

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0 910	Continued From page 14 MN 55414. R3 R3's [Licensee] Resident Contract for Assisted Living signed on February 6, 2023, indicated R3's occupancy date was February 6, 2023, and the facility address and address for assisted living licensee was 1073 26th Avenue SE Minneapolis, MN 55414. On May 13, 2026, at 11:28 a.m., while reviewing R3's contract with LALD/CNS-A, LALD/CNS-A stated R3's contract was the updated version being used for all residents and they acknowledged the contract did not have an updated address. The licensee's Notifications policy dated February 24, 2022, indicated prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE	0 950		

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0 950	Continued From page 15 FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative on its own separate page for two of two residents (R2, R3). 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).	0 950		

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0 950	Continued From page 16 The findings include: On May 11, 2026, at 10:30 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had a census of three (3) residents. On May 12, 2026, at 3:50 p.m., the surveyor asked for clarification on admission dates for all residents because dates in medical records did not match dates on the current roster. LALD/CNS-A provided the admission dates as follows: -R2 was admitted on June 12, 2023; and -R3 was admitted on February 6, 2023. R2's [Licensee] Resident Contract for Assisted Living signed on June 12, 2024, indicated R2's occupancy date was June 12, 2022. R3's [Licensee] Resident Contract for Assisted Living signed on February 6, 2023. R2 and R3's assisted living contracts did not include the required statutory notice language about designated representative on a document separate from the contract. On May 13, 2026, at 11:28 a.m., while reviewing R3's contract with LALD/CNS-A, LALD/CNS-A stated R3's contract was the updated version being used for all residents and they were not familiar with the requirements, so they were shown the statute requirement. The licensee's Notifications policy dated February 24, 2022, indicated prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the	0 950		

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0 950	Continued From page 17 resident, the resident's designated representative and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 12, 2026, at 3:50 p.m., the surveyor	0 970		

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0 970	Continued From page 18 asked for clarification on admission dates for all residents because dates in medical records did not match dates on the current roster. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided the admission dates as follows: -R2 was admitted on June 12, 2023; and -R3 was admitted on February 6, 2023. R2's and R3's [Licensee] Resident Contract for Assisted Living signed on June 12, 2024, and February 6, 2023, respectively, included the following section that included language that waived the licensee's liability: -Provisions Related to Liability section read, "Damage of Injury to Resident of Resident's Property. We are not responsible for any damage or injury suffered by you, your property, ... that was caused by us." On May 13, 2026, at 11:28 a.m., LALD/CNS-A stated during their last survey, they noted a waiver of liability in their contract and thought they removed it all. The licensee's Notifications policy dated February 24, 2022, indicated prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 19 (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. This MN Requirement is not met as evidenced by: Based interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance letter was received as required for one (1) of seven (7) employees (unlicensed personnel (ULP)-B). 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: During entrance conference on May 11, 2026, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	01290	During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 20 stated the staff schedule included 8-hour shifts and 12-hour shifts depending on the day of the week and one ULP was scheduled for each shift. The licensee's Staff Listing dated May 11, 2026, indicated ULP-B was hired on January 7, 2026, to provide assisted living services to residents. R2's medication administration record (MAR) dated May 2026, showed ULP-B documented, by initialing, that they provided medications to R2 from May 2-11, 2026. On May 11, 2026, at 1:33 p.m., LALD/CNS-A stated they were having difficulties getting into NETStudy so the surveyor requested the NETStudy 2.0 roster (web-based system used by the Minnesota Department of Human Services (DHS)) from their supervisor. On May 11, 2026, at 1:36 p.m., the surveyor compared the licensee's staff list to the NETStudy 2.0 roster dated May 11, 2026. The surveyor did not observe ULP-B listed on the NETStudy 2.0 roster for health facility identification number (HFID) 36747. On May 12, 2026, at 9:31 a.m., the supervisor indicated no one by ULP-B's name or ULP-B's date of birth was listed in the NETStudy system. The licensee's May 2026 staff schedule listed a week 1 and week 2 rotation. Week 1 indicated ULP-B was scheduled to work Monday, Tuesday, Wednesday and Thursday and Sunday from 8:00 p.m. to 8:00 a.m. (overnight shift). Week 2 indicated ULP-B was scheduled to work Tuesday, Wednesday, Thursday, and Sunday (same hours).	01290		

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01290	Continued From page 21 During interview on May 12, 2026, at 10:20 a.m., owner/administrator (O/A)-D stated he was the person who completed background studies for newly hired staff. When asked if ULP-B had a BGS clearance, O/A-D stated he did not have one for ULP-B because they have been having trouble logging into DHS NETStudy system to conduct the BGS. O/A-D stated he had been attempting to rectify this issue since October 2025, and because he personally knew ULP-B since he was a child and trusted ULP-B, he felt it was okay for ULP-B to begin working with licensee's residents. O/A-D stated ULP-B was the only employee that did not have a cleared BGS and at the time, he needed to fill the overnight position as the previous employee was no longer working. The licensee's Recruitment and Hiring Policy dated February 24, 2022, indicated the criminal background check will be submitted to DHS following the step-by-step procedure established by DHS: a. The director or designee is responsible for initiating the criminal BGS for new employees b. NETStudy 2.0 (or current version) will be used for the background check c. The employees will be directed to locations established by DHS to obtain fingerprint scans d. Employees will be instructed that photographic identification will be required e. Employees/study subjects may enter their own BGS demographic information using the facility identification code provided f. Results of the BGS will be maintained in the employee's personnel file. The policy did not specify whether an employee could begin working with residents prior to having a cleared BGS.	01290		

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01290	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	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 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	01530		

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01530	Continued From page 23 consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff completed the initial two (2) hours of mental illness and de-escalation training within the required time frame for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ULP-B ULP-B was hired January 7, 2026, to provide direct care and services for the licensee's residents. On May 12, 2026, at 8:40 a.m., unlicensed personnel (ULP)-C set up and administered 13 pills to R2. ULP-B's training transcript dated May 11, 2026,	01530		

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01530	Continued From page 24 had documentation of completing one (1) hour of Mental Illness-Response Strategies on March 23, 2026. ULP-B's record lacked documentation of completing two (2) hours of mental illness and de-escalation training within 160 working hours of employment date. ULP-C ULP-C was hired August 26, 2024, to provide direct care and services for the licensee's residents. ULP-C's training transcript dated May 11, 2026, had documentation of completing (1) hour of Mental Illness-Response Strategies on February 23, 2026. ULP-C record lacked documentation of completing two (2) hours of Mental Illness and de-escalation training prior to July 1, 2025. On May 13, 2026, at approximately 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated house manager (HM)-E was usually responsible for assigning training courses for annual training and new hires, but if HM-E was not sure about something, HM-E could contact registered nurse (RN)-H who was very knowledgeable. LALD/CNS-A was aware mental illness training became a requirement as of July 1, 2025, and thought three (3) hours was required initially. LALD/CNS-A then asked to call RN-H, and put her on speaker for surveyor to hear. RN-H thought 3 hours of mental illness was required initially, then two hours annually. After surveyor explained hte statute requirement, LALD/CNS-A confirmed all staff were only receiving one hour of initial mental	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 25 illness training. The licensee's Mental Illness, De-escalation, and Crisis Response Policy dated July 14, 2025, indicated staff would receive and maintain required training in mental illness and de-escalation as required by Minnesota Statutes 144G.63 and 144G.64, and this training would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	01620		

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	36747	A. BUILDING: _____ B. WING _____	05/13/2026

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01620	Continued From page 26 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: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 27 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: R2 was admitted on August 27, 2024, and had diagnoses including schizoaffective disorder, bipolar type, type 2 diabetes mellitus, and constipation. R2's Service Plan - Modification signed April 1, 2026, indicated R2 received assistance with medication management, bathing, appointments, bedmaking, behavior management, blood glucose monitoring, housekeeping, and laundry. On May 12, 2026, at 8:40 a.m., unlicensed personnel (ULP)-C showed the surveyor using R2's blood glucose testing kit what steps would be taken to check the blood sugar using a blood drop. ULP-C explained that R2's blood glucose was 119 earlier in the morning. R2's provider orders dated July 9, 2025, ordered to check blood glucose daily in the morning. R2's nursing assessment dated December 8, 2025, indicated R2 denied active diabetic problems and at the end of the assessment, indicated that day, R2's blood glucose was 138. R2's nursing assessment dated March 8, 2026, indicated R2 denied active diabetic problems and at the end of the assessment indicated that day, R2's blood glucose was 142.	01620		

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01620	Continued From page 28 R2's nursing assessments failed to address a list of treatments, including type, frequency, and level of assistance needed as required. On May 13, 2026, at 10:00 a.m., ULP-C stated LALD/CNS-A trained him on how to use R2's Freestyle Libre (continuous glucose monitoring system) and was told to use the finger poke kit as a backup if the monitor or sensor malfunctioned. On May 13, 2026, at 10:10 a.m., LALD/CNS-A stated she put "denied diabetic concerns" because R2 did not require insulin but confirmed R2 received oral hypoglycemic (medication that help lower blood glucose levels by stimulating insulin release) and required assistance with blood glucose monitoring. LALD/CNS-A stated R2's treatment was not listed in the assessment and "must have missed it." The licensee's Comprehensive Nursing Assessment policy dated February 24, 2022, indicated a registered nurse would conduct a comprehensive assessment utilizing a uniform assessment tool for all residents to include current treatments the resident requires, including the type, frequency and level of assistance needed. Minnesota Administrative Rule 4659.0150, subpart 1 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

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01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 30 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 12, 2026, at 3:50 p.m., the surveyor asked for clarification on admission dates for all residents because dates in medical records did not match dates on the current roster. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided the admission dates as follows: -R2 was admitted on June 12, 2023; and -R3 was admitted on February 6, 2023. R2 R2's diagnoses included schizoaffective disorder, bipolar type, type 2 diabetes mellitus, and constipation. On May 12, 2026, at 8:40 a.m., unlicensed personnel (ULP)-C set up and administered 13 pills to R2. R2's Service Plan - Modification signed April 1, 2026, indicated R2 received assistance with medication management, bathing, appointments, bedmaking, behavior management, blood glucose monitoring, housekeeping, and laundry. R3 R2's diagnoses included brain stem stroke syndrome.	01650		

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01650	Continued From page 31 R3's Service Plan - Modification signed April 1, 2026, indicated R3 received assistance with ambulation, dressing, grooming, housekeeping, laundry, behavior management, meal assistance, medication administration, and nail care. R2 and R3's service plans lacked the following required content: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility (facility address was incorrect); and - the names and contact information of person the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On May 12, 2026, at 12:00 p.m., LALD/CNS-A stated the licensee began using Residex (electronic health record) about a year ago and used the service plan from Residex for all residents. LALD/CNS-A stated Residex only had one type of service plan which did not include all of the required content and would contact Residex to include the missing content. The licensee's Service Plan policy dated February	01650		

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01650	Continued From page 32 24, 2022, indicated an individualized service plan was implemented for all residents. The policy also indicated the missing content listed above would be included in each service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure transcription for prescriptions was completed for one of one resident (R2) who had 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	01760		

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01760	Continued From page 33 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: R2's diagnoses included schizoaffective disorder, bipolar type, type 2 diabetes mellitus, and constipation. R2's Service Plan - Modification signed April 1, 2026, indicated R2 received assistance with medication management, bathing, appointments, bedmaking, behavior management, blood glucose monitoring, housekeeping, and laundry. On May 12, 2026, at 8:40 a.m., before medication administration, the surveyor observed R2's medication drawer which contained medication packaging from the pharmacy, a pharmacy bottle of Tylenol, a bubble pack containing as needed (PRN) risperidone (antipsychotic), and an unopened box containing ipratropium bromide 0.06% nasal solution. R2's medication administration record (MAR) dated May 2026, lacked ipratropium bromide. On May 12, 2026, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and the surveyor observed R2's medication drawer and the surveyor asked LALD/CNS-A where ipratropium bromide came from, she explained R2 was recently seen at the hospital for heart palpitations and would search for the order. At 3:00 p.m., LALD/CNS-A provided the ipratropium bromide order which	01760		

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01760	Continued From page 34 was provided by the pharmacy and stated the provider ordered it on May 4, 2026. LALD/CNS-A stated the ipratropium bromide was not on the MAR and would need to add it so staff could start administering it. At 3:20 p.m., LALD/CNS-A provided an updated MAR that included the missing medication. R2's E-Script New Prescription Request electronically sent to Genoa Pharmacy by the provider on May 4, 2026, ordered ipratropium bromide (Atrovent) 0.06% nasal solution spray, one spray in the mouth at bedtime for drooling. The licensee's Prescriber's Orders policy dated February 24, 2022, indicated the registered nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940		

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01940	Continued From page 35 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. 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) specified, in writing, specific instructions and documented those instructions in the resident record for one of one resident (R2) with treatments tasks. 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:	01940		

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01940	Continued From page 36 During the entrance conference on May 11, 2026, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A confirmed the licensee provided treatment and therapy services to residents as prescribed. R2 was admitted on August 27, 2024, and had diagnoses including schizoaffective disorder, bipolar type, type 2 diabetes mellitus, and constipation. R2's Service Plan - Modification signed April 1, 2026, indicated R2 received assistance with medication management and blood glucose monitoring. On May 12, 2026, at 8:40 a.m., unlicensed personnel (ULP)-C showed the surveyor using R2's blood glucose testing kit what steps would be taken to check the blood sugar using a blood drop. ULP-C explained that R2's blood glucose was 119 earlier in the morning. R2's Quarterly Review (provider orders) signed on July 9, 2025, produced by R2's electronic health record, included a list of active medications by showing medication name, start date, strength, route, frequency, and time to be administered, then under treatment and therapy section, the task included recording blood glucose daily at 9:00 a.m., with instructions: wearing gloves and following agency procedure, check blood glucose, and record. Notify RN (registered nurse) if: if blood glucose is less than 70 or greater than 250. RN will notify the MD (medical doctor) if [R2's name] has a blood glucose of 250 for 3 consecutive days. R2's After Visit Summary (provider orders) dated	01940		

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01940	Continued From page 37 August 5, 2024, included Freestyle Libre 2 reader to monitor blood glucose levels, and Freestyle Libre 2 sensor, use one (1) sensor every 14 days to monitor blood glucose levels. R2's RN assessment dated March 8, 2026, did not indicate whether R2 required assistance with blood glucose monitoring. R2's Service Recap Summary-Month dated May 1-10, 2026, included daily staff initials after "Record-Blood Glucose" at 9:00 a.m. On May 13, 2026, at 10:00 a.m., ULP-C stated LALD/CNS-A trained him on how to use R2's Freestyle Libre 2 (continuous glucose monitoring system) and was told to use the finger poke kit as a backup if the monitor or sensor malfunctioned. At this time, ULP-C pulled up R2's electronic health record and showed the details of "Record-Blood Glucose" which did not include instructions to use the Freestyle Libre 2 reader. On May 13, 2026, at 10:10 a.m., LALD/CNS-A stated R2's record did not specify instructions when to use the finger poke method and Freestyle Libre 2 reader. The licensee's Treatment and Therapy Management policy dated February 24, 2022, indicated the RN was responsible for assessing and developing the treatment and/or therapy service plan for residents. The RN would prepare an individualized treatment management plan for each resident receiving ordered or prescribed treatments to include identification of treatment tasks delegated to ULP. No further information was provided.	01940		

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01940	Continued From page 38 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of two unlicensed personnel (ULP)-C observed during medication administration. 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: R2 had diagnoses including schizoaffective disorder, bipolar type, type 2 diabetes mellitus, and constipation. R2's Service Plan - Modification signed April 1,	02320		

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02320	Continued From page 39 2026, indicated R2 received assistance with medication management, bathing, appointments, bedmaking, behavior management, blood glucose monitoring, housekeeping, and laundry. R2's Med Admin Summary-Month dated May 2026, indicated R2 took the following morning medications: alfuzosin (relaxes prostate muscles for easier urine flow), glipizide (stimulates insulin production), levocarnitine (treat carnitine deficiency), metformin (reduces glucose absorption), omeprazole (treats excess stomach acid), propranolol (treats irregular heart rate), risperidone (treats schizophrenia symptoms), and vitamin D3 (supplement). On May 12, 2026, at 8:40 a.m., the surveyor observed ULP-C setting up R2's medications for administration. R2's morning oral medications had been set up by the pharmacy in one blister package. The package listed the name and dosage of each medication on the top of the blister package. ULP-C then grabbed a separate foiled bubble package which had one tablet per bubble. ULP-C tore off two bubbles and placed each tablet into a small medication cup then opened the pharmacy package and poured 11 medications into the same medication cup. ULP-C had R2 sit at a table and provided a glass of water for R2 to take his medications with. On May 12, 2026, at 8:55 a.m., ULP-C stated he completed medication training on Educare (training platform) and the registered nurse (RN) checked him off. When asked about checking the medication administration record (MAR) during medication administration, ULP-C stated he would sometimes check the MAR at the beginning of a pharmacy cycle (medications were delivered monthly) to make sure there were no	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36747	A. BUILDING: _____ B. WING _____	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOME SERVICES LLC	6051 4TH ST NE FRIDLEY, MN 55432

(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
02320	Continued From page 40 medication changes within the packaging. He stated he was trained to use the MAR for each administration. ULP's Skill Competency Medication Administration-Routes dated February 26, 2026, indicated ULP-C was competent of oral medication administration by performing the 3 safety checks on the "Simple Check List." On May 12, 2026, at 3:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all staff were supposed to be checking the MAR before administering medications and said ULP-C may have been "too confident" because he had been working for licensee a long time. The licensee's Medication Administration policy dated February 24, 2022, indicated residents were entitled to the safe administration of medications by qualified personnel according to a written medication management plan. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: purpose, dosage, route, frequency, instructions related to the medication and specific to the residents, as appropriate, side effects, and resident allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Healing Home Services LLC
6051 4th St NE
Fridley, MN 55432
Anoka County
Parcel:

Phone: 651-703-6267
healinghomeservicesllc@gmail.com

License Info

License: HFID 36747
MAGRAD HUSSEIN
Risk:
License:
Expires on:
CFPM: ABDULLAHI HUSSEN
CFPM #: 57331; Exp: 3/14/2028

Inspection Info

Report Number: F1029261157
Inspection Type: Full - Single
Date: 5/11/2026 Time: 2:04:05 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 5
Total Priority 2 Orders: 5
Total Priority 3 Orders: 2
Delivery:

New Order: 2-100 Supervision
2-103.11C *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0035C The person in charge must ensure that employees and other persons entering the food preparation, food storage and warewashing areas of the establishment comply with the rule.
COMMENT: TEMPERATURE ABUSED ITEMS IDENTIFIED IN MAIN FRIDGE. PIC INSTRUCTED TO EXERT ACTIVE MANAGERIAL CONTROL TO ENSURE STAFF AND CLIENTS ARE NOT LEAVING COOLER DOORS OPEN AND FOODS-BEVERAGES OUT FOR UNSAFE AMOUNTS OF TIME.
Comply By: 5/11/2026 Originally Issued On: 5/11/2026

! **New Order: 3-200B Food Characteristics:Receiving: temperature, condition**
3-202.11C *Priority Level: Priority 1 CFP#: 12*
MN Rule 4626.0165C Discontinue sale or service of raw eggs that are not received at 45 degrees F or below.
COMMENT: RECENTLY RECEIVED RAW SHELL EGGS ABOVE 45F DISCARDED BY PIC. PIC INSTRUCTED TO ENSURE STAFF ARE TAKING STEPS TO ENSURE RAW SHELL EGGS ARE BEING TRANSPORTED AND DELIVERED AT NO MORE THAN 45F.

Comply By: 5/11/2026 Originally Issued On: 5/11/2026

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: RAW SHELL EGGS ABOVE RTE ITEMS AND HIGH CONTACT SURFACES IN FRIDGE. PIC INSTRUCTED TO STORE THE RAW SHELL EGGS BELOW RTE ITEMS AND/OR IN A LEAK-PROOK CONTAINER WITH HIGH SIDE WALLS.
Comply By: 5/11/2026 Originally Issued On: 5/11/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-307.11 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.
COMMENT: PAINT FLECKING OFF OF INTERIOR OF MICROWAVE OVEN. PIC INSTRUCTED TO REPAIR OR REPLACE.
Comply By: 5/22/2026 Originally Issued On: 5/11/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: COLD HELD TCS ITEMS IN DANGER ZONE IN MAIN FRIDGE DISCARDED BY PIC. PIC INSTRUCTED TO ADJUST, REPAIR, OR REPLACE COOLER TO ENSURE SAFE COLD HOLDING TEMPERATURES AND TO VERIFY SAFE COLD HOLDING TEMPERATURES THROUGHOUT COOLER PRIOR TO PLACING ADDITIONAL TCS ITEMS WITHIN.
Comply By: 5/11/2026 Originally Issued On: 5/11/2026

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: MIN/MAX THERMOMETER AND THERMAL STICKERS ABSENT. PIC INSTRUCTED TO MAINTAIN ONSITE MEANS OF VERIFYING SANITIZING TEMPERATURES IN DISHWASHER.
Comply By: 5/15/2026 Originally Issued On: 5/11/2026

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114A *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.
COMMENT: DISINFECTANT WIPES USED IN KITCHEN AS FOOD CONTACT SURFACE WIPES. PIC INSTRUCTED TO DISCONTINUE AND, IF USING DISPOSABLE WIPES ON FOOD CONTACT SURFACES, TO ONLY USE WIPES INTENDED FOR FOOD CONTACT SURFACES.
Comply By: 5/11/2026 Originally Issued On: 5/11/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: MAIN FRIDGE NOT HOLDING AT 41F OR LESS. PIC INSTRUCTED TO ADJUST, REPAIR, OR REPLACE TO ENSURE COOLER IS MECHANICALLY SOUND TO HOLD TCS ITEMS AT 41F OR LESS.

DISHWASHER NOT SANITIZING. PIC INSTRUCTED TO ADJUST, REPAIR, OR REPLACE TO ENSURE CONSISTENT SANITIZING.
Comply By: 5/29/2026 Originally Issued On: 5/11/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: DISHWASHER NOT REACHING MANUFACTURER'S SANITIZING TEMPERATURES. PIC INSTRUCTED TO REPAIR OR REPLACE DISHWASHER TO ENSURE MANUFACTURER'S SANITIZING TEMPERATURES ARE REACHED AND TO CHEMICALLY SANITIZE EQUIPMENT AND UTENSILS IN THE INTERIM AS A SHORT TERM SOLUTION.
Comply By: 5/11/2026 Originally Issued On: 5/11/2026

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT: HANDWASHING SINK FILLED WITH DISHES. CORRECTED DURING INSPECTION. PIC INSTRUCTED TO ENSURE THE HANDWASHING SINK IS ACCESSIBLE AND USED FOR HANDWASHING.
Comply By: 5/11/2026 Originally Issued On: 5/11/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: PAPER TOWELS ABSENT AT KITCHEN AND TOILET ROOM HANDWASHING SINKS. PIC INSTRUCTED TO ENSURE PAPER TOWELS ARE PRESENT AT HANDWASHING SINKS OR A DIFFERENT SAFE AND EFFECTIVE MEANS OF HAND DRYING IS MADE AVAILABLE.

CONTINUOUS TOWEL SYSTEMS ARE AN OPTION FOR HAND DRYING WHEN DISPOSABLE PAPER TOWELS ARE NOT A VIABLE OPTION.
Comply By: 5/11/2026 Originally Issued On: 5/11/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.111C *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.
COMMENT: INSECT POPULATION IN KITCHEN. PIC INSTRUCTED TO ELIMINATE POINTS OF ENTRY AND TAKE STEPS TO ELIMINATE PEST POPULATION FROM KITCHEN AREA.
Comply By: 5/11/2026 Originally Issued On: 5/11/2026

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION CONDUCTED AS PART OF HRD SURVEY OF ALF. NURSING SURVEYOR: ANNA BOHNEN.

ESTABLISHMENT IS RESIDENTIAL IN NATURE: LAMINATE FLOOR, WOOD CABINETRY AND MILLWORK, TILE BACKSPLASH, SMOOTH PAINTED WALLS AND CEILING, COMPOSITE COUNTERTOP. INSPECTION CONDUCTED WITH ESTABLISHMENT REPRESENTATIVES AND PERSON IN CHARGE, MAGRAD HUSSEIN, LALD. IDENTIFIED ISSUES DISCUSSED WITH ESTABLISHMENT REPRESENTATIVES AND PIC. TOPICS REVIEWED: EMPLOYEE ILLNESS LOGGING, REPORTING, AND EXCLUSION REQUIREMENTS; TEMPERATURE CONTROL; SANITIZING; EMPLOYEE HYGIENE AND HANDWASHING; PROTECTION FROM CONTAMINATION.

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 F1029261157 from 5/11/2026

MAGRAD HUSSEIN
LALD PERSON IN CHARGE

Trevor McCliment

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

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

Temperature Observations/Recordings

Establishment Info

Healing Home Services LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1029261157
Inspection Type: Full
Date: 5/11/2026
Time: 2:04:05 PM

New Record: Product/Item/Unit: CUT MELON**; Temperature Process:** Cold-Holding
Location: MAIN FRIDGE at 45 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: YOGURT**; Temperature Process:** Cold-Holding
Location: MAIN FRIDGE (DOOR) at 48 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: RAW SHELL EGG**; Temperature Process:** Cold-Holding
Location: MAIN FRIDGE at 51 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: RAW SHELL EGG**; Temperature Process:** Cold-Holding
Location: MAIN FRIDGE at 54 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: INTERNAL THERMOMETER**; Temperature Process:** Cold-Holding
Location: 2ND FRIDGE at 32 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: COTTAGE CHEESE**; Temperature Process:** Cold-Holding
Location: MAIN FRIDGE at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Healing Home Services LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1029261157
Inspection Type: Full
Date: 5/11/2026
Time: 2:04:05 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: **Less Than** 150 Degrees F.
Comment:
Violation Issued?: Yes

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

Healing Home Services LLC
6051 4th St NE
Fridley, MN 55432
Anoka County
Parcel:

Phone: 651-703-6267
healinghomeservicesllc@gmail.com

License Info

License: HFID 36747
MAGRAD HUSSEIN
Risk:
License:
Expires on:
CFPM: ABDULLAHI HUSSEN
CFPM #: 57331; Exp: 3/14/2028

Inspection Info

Report Number: F1029261176
Inspection Type: Follow-up - Single
Date: 6/5/2026 Time: 4:10:33 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

ESTABLISHMENT CLEARED PREVIOUSLY ISSUED CORRECTION ORDERS.

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 F1029261176 from 6/5/2026

MAGRAD HUSSEIN
PERSON IN CHARGE

Trevor McCliment

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

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

Sanitizer Observations/Recordings

Establishment Info

Healing Home Services LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1029261176
Inspection Type: Follow-up
Date: 6/5/2026
Time: 4:10:33 PM

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36747016-0	**Date:** May 12, 2026
Facility Name: Healing Home Services LLC	
Facility Address: 6051 4th street NE, Fridley, MN 55432	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. The design, construction and installation of fuel-fired appliances shall be in accordance with the International Fuel Gas Code and the International Mechanical Code [Minn. Stat. 144G.45 subd. 2; MSFC 603.1.2]

   Comments: The venting for the gas fired water heater had a negative pitch on it causing the vent to not properly convey the byproducts of combustion to the exterior of the facility.

☒ **TAG IDENTIFICATION: 0810**

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

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that 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.

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

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: House manager (HM)-E lacked documentation that staff had been trained on the FSEP. HM-E stated that the training for staff was verbal and that they didn't have any written documentation of staff training on the FSEP.

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: House manager (HM)-E lacked documentation that residents had been offered trained on the FSEP. HM-E stated that the training for resident was verbal and that they didn't have any written documentation of resident training on the FSEP.

6. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: HM-E provided drill documentation that lacked times on the drills to verify that each shift had completed fire drills. MH-E stated that they did not have any documentation of the times for when the drills were completed.