Electronically Delivered

June 1, 2026

Licensee
Aspire Senior Living LLC
5206 Brighton Lane
Mounds View, MN 55112

RE: Project Number(s) SL41831015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on April 15, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health 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

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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41831	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE SENIOR LIVING LLC	5206 BRIGHTON LN MOUNDS VIEW, MN 55112

(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: SL41831015-0 On April 13, 2026, through April 15, 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 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 April 13, 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		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 4 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 April 13, 2026, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee was aware of the required contents of the employee record. ULP-B and ULP-C were hired on February 8, 2026, and November 8, 2025, respectively, to provide direct assisted living services to residents at the facility. On April 14, 2026, at 8:31 a.m., ULP-B stated R2's blood glucose was checked prior to the surveyor's arrival which was 128. ULP-B set up R2's oral medications first then set R2's insulin lispro kwikpen (rapid-acting) to two (2) units, and Lantus Solostar pen (long-acting insulin) to five (5) units then applied needles to each pen. ULP-B then injected both insulins into R2's left lower quadrant of her abdomen. The surveyor did not observe ULP-B wipe the rubber seal with an alcohol wipe or prime the needles by wasting two units to determine the pen was working and remove any air bubbles to ensure an accurate dose. On April 14, 2026, at approximately 11:45 a.m., ULP-B stated her training included shadowing another ULP for two days, complete online medication administration training, then CNS-A	0 650		

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0 650	Continued From page 5 observed ULP-B perform blood glucose check and medication administration prior to working on their own. During phone interview on April 14, 2026, at 2:47 p.m., ULP-C confirmed they worked for licensee and began employment around November 2025. ULP-C stated they were trained by another ULP on how to administer medications, insulin, and perform blood glucose checks. ULP-C stated they were trained to prime insulin pens and trained how to use R2's specific blood glucose reader. Prior to working on their own, ULP-C stated CNS-A observed them perform the stated tasks. ULP-B and ULP-C's employee record lacked training and competency evaluations for insulin administration and lacked competency evaluations for resident specific blood glucose testing. On April 14, 2026, at 3:01 p.m., CNS-A stated staff would watch CNS-A administer insulin then observe staff perform the task. CNS-A stated staff were trained to prime insulin pens. Staff were also trained how to use R2's blood glucose reader and apply the sensor on R2's arm. CNS-A stated she used the insulin pen medication protocol as part of her training but stated she did not have documentation of training and competency evaluation on insulin administration or competency evaluation on R2's blood glucose reader/sensor for any staff. CNS-A stated she would begin documenting those going forward. The licensee's Staff Competency policy dated August 1, 2025, indicated all residents would receive quality service delivered by staff who are educated and competent in the delivery of assisted living services. The following	0 650		

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0 650	Continued From page 6 documentation would be maintained related to competency evaluations: a. Facility name, location and license number b. Name of topic and methodology c. Date and total time d. Name/title of instructor and evaluator with signatures and a statement attesting that the employee successfully passed the training and competency evaluation e. Name/title of staff person completing the competency evaluation and a statement attesting that the person successfully completed the training as described. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person	0 650		

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0 650	Continued From page 7 successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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:	0 680		

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0 680	Continued From page 8 Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all required content as defined in Centers for Medicare and Medicaid Services (CMS) Appendix Z. 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan, reviewed August 1, 2025, lacked evidence of the following required content: -documentation of reviewing missing resident plan at least quarterly (last documented review on August 1, 2025); -process for EP collaboration (with local, tribal, regional, state and federal EP); -procedures for tracking of staff and residents; -procedure to address safe evacuation from the facility including consideration of care/treatment needs of evacuees; -roles under a Waiver Declared by Secretary (section 1135 of the Act); and -sharing information on occupancy/needs. On April 13, 2026, at 2:10 p.m., clinical nurse supervisor (CNS)-A stated they did not review the missing resident plan quarterly and was unsure what section 1135 was. CNS-A could not locate the collaboration with local, tribal, regional, state, and federal and would ask someone. CNS-A	0 680		

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0 680	Continued From page 9 stated the EP did not include procedures for tracking staff and residents and stated they did not have an "ERT (Emergency Response Team)" as stated in the EP and would need to customize their template further. CNS-A provided their Resident-Specific Evacuation Plan, undated, which included four residents which one of the residents was already discharged. The licensee's Emergency Preparedness policy dated August 1, 2025, indicated the licensee would 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 August 1, 2025, indicated the missing resident procedure would be reviewed by the director and CNS at least quarterly. Changes to the plan would be documented. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 810	Continued From page 10	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be 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	0 810		

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0 810	Continued From page 11 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 April 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 900	Continued From page 12 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the Office of Ombudsman for Long-Term Care (OOLTC) with a complete unsigned copy of the assisted living contract. This had the potential to affect all current residents. 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:	0 900		

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	41831	A. BUILDING: _____ B. WING _____	04/15/2026

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0 900	Continued From page 13 The licensee held a provisional assisted living license effective June 13, 2025, and set to expire on June 12, 2026. The licensee's Notice of Providing Assisted Living Services indicated they began providing services on September 2, 2025. On April 14, 2026, at 12:00 p.m., clinical nurse supervisor (CNS)-A confirmed a blank contract was not sent to OOLTC, just to Minnesota Department of Health (MDH) with the Notice of Providing Assisted Living Services. On April 14, 2026, at 10:36 a.m., via email, a regional ombudsman indicated OOLTC did not receive an unsigned facility contract and encouraged the licensee to send one as soon as possible. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what	0 930		

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0 930	Continued From page 14 circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with all required content for one of one resident (R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 13, 2026, at 12:57 p.m., clinical nurse supervisor (CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On April 13, 2026, at approximately 3:50 p.m., CNS-A stated R2's contract was the contract used for all residents. R2 was admitted to the licensee on September 23, 2025.	0 930		

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0 930	Continued From page 15 R2's Master Care Plan updated March 24, 2026, indicated R2 received assistance with medication administration, oxygen therapy, blood glucose monitoring, bathing, grooming, dressing, toileting, and behavior management. On April 14, 2026, at 8:31 a.m., the surveyor observed unlicensed personnel (ULP)-B administer insulin to R2 prior to serving breakfast and administer oral medications after R2 was done eating. R2's [Licensee name] Assisted Living Contract was signed on September 21, 2025. R2's assisted living contract lacked clear and conspicuous notice of the right under section 144G.54 to appeal the termination of an assisted living contract. On April 14, 2026, at 12:00 p.m., the surveyor asked CNS-A to locate the missing required content. CNS-A stated she would try to locate it. At 12:30 p.m., CNS-A stated she would obtain a new contract from Home Care Consultants because she was unable to locate the required content. The licensee's Notifications policy dated August 1, 2025, 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	0 930		

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0 970	Continued From page 16	0 970		
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 observation, interview, and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on September 23, 2025. R2's Master Care Plan updated March 24, 2026, indicated R2 received assistance with medication administration, oxygen therapy, blood glucose monitoring, bathing, grooming, dressing, toileting, and behavior management.	0 970		

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0 970	Continued From page 17 R2's [Licensee name] Assisted Living Contract was signed by R2 on September 21, 2025, read the following waivers of liability: -on page 12, under "Miscellaneous Provisions 1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, ..., and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident .... The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident ....unless caused by the negligence of [Licensee] or its employees or agents." -on page 14, under "Indemnification: [Licensee] shall not be liable for any damage or injury to the resident... or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee]." On April 13, 2026, at 3:50 p.m. clinical nurse supervisor (CNS)-A indicated all residents used the same contract and acknowledged the contract included a waiver of liability. On April 14, 2026, at 8:31 a.m., the surveyor observed unlicensed personnel (ULP)-B administer insulin to R2 prior to serving breakfast and administered oral medications after R2 was	0 970		

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0 970	Continued From page 18 done eating. The licensee's Notifications policy dated August 1, 2025, 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		
01730 SS=D	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;	01730		

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01730	Continued From page 19 (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 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 develop an individualized medication management plan with the required content 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 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:	01730		

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01730	Continued From page 20 R2 was admitted to the licensee on September 23, 2025, and had diagnoses including diabetes mellitus, type II, schizoaffective disorder, paranoid type, and acute respiratory failure with hypoxia and hypercapnia. R2's Master Care Plan updated March 24, 2026, indicated R2 received assistance with medication administration, oxygen therapy, blood glucose monitoring, bathing, grooming, dressing, toileting, and behavior management. On April 14, 2026, at 8:31 a.m., ULP-B stated R2's blood glucose was checked prior to the surveyor's arrival which was 128. While sitting at a desk with the electronic medication administration record (eMAR) open, ULP-B set up R2's oral medications first then set R2's insulin lispro kwikpen (short-acting) to two (2) units and set Lantus Solostar pen (long-acting insulin) to five (5) units. ULP-B then injected both insulins into R2's left lower quadrant of her abdomen near each other. During the insulin set up, the surveyor did not observe documentation instructions related to injection sites. R2's medical record lacked instruction on documenting injection sites. During interview on April 14, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated she instructed staff to document insulin injection sites within the notes on the eMAR, but after review of the eMAR together, CNS-A observed that staff were only documenting "stomach" at times and did not specify where on the stomach. CNS-A stated she would instruct staff to be more specific when documenting in the notes and not to inject two different insulins in the same area.	01730		

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01730	Continued From page 21 ULP-B's record included a Insulin Pen Medication Protocol with Reusable Pen document dated January 30, 2026, which provided step-by-step instructions for insulin pen administration. During interview on April 14, 2026, at 3:01 p.m., CNS-A explained she had trained staff using their Insulin Pen Medication Protocol with Reusable Pen document which indicated the following instructions: -site selection for injection should be rotated with each dose; -check the medication profile for the location of the last injected site; and -chart medication, dose, route, site, time, and date with signature on the MAR. The licensee's Service Plan for Medication Management policy dated August 1, 2025, indicated the written medication management plan would include resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. The Diabetes Strong website, Diabetes Strong Insulin Injection Sites: The Best Places to Inject, updated July 2, 2024, indicated not to inject two different types of insulin in the same area at the same time as some insulins can affect the potency, absorption, and efficacy of other insulins if they "meet" each other in that subcutaneous tissue. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01730		

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01730	Continued From page 22 days	01730		
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 insulin was administered as prescribed and failed to document in the resident record when not administered as prescribed or any follow-up procedures that were provided to meet the resident's needs for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	01760		

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01760	Continued From page 23 The findings include: R2 was admitted to the licensee on September 23, 2025, and had diagnoses including diabetes mellitus, type II, schizoaffective disorder, paranoid type, and acute respiratory failure with hypoxia and hypercapnia. R2's signed physician order dated March 30, 2026, included the following orders for diabetes management: -insulin lispro 100unit (u)/milliliters (ml) injection (rapid-acting), inject 2u subcutaneously (subq) three times a day before meals; and -Lantus solostar 100u/ml injection (long-acting), inject 5u subq once daily at 9:00 a.m., and inject 30u subq once daily at bedtime. R2's Master Care Plan updated on March 24, 2026, indicated medications were administered as ordered, with staff responsible for proper preparation, verification, and timely delivery. Staff would assist the resident with administering rapid-acting insulin three times per day with meals. R2's Med (medication) Admin (administration) Summary-Actual-Month dated March 2026, included the following: -Lantus solastar [sic] 100u/ml, inject 5u subq once daily at 9:00 a.m., "Instructions: Pull cap and wipe with alcohol, place fresh needle on pen each time. Prime pen with 2 units and depress in sick/garbage. Dial up 5 units, pick injection site and clean with alcohol wipe. Push needle into skin and hold for 10 counts then remove. Place needle in sharps container (NEVER RECAP) always date the pen when new one is open (good for 28 days);"	01760		

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01760	Continued From page 24 -Lantus 100u/ml, inject 30u once daily at bedtime, "Instructions: Pull cap and wipe with alcohol, place fresh needle on pen each time. Prime pen with 2 units and depress in sick/garbage. Dial up 30 units, pick injection site and clean with alcohol wipe. Push needle into skin and hold for 10 counts then remove. Place needle in sharps container (NEVER RECAP) always date the pen when new one is open (good for 28 days);" and -insulin lispro 100u/ml-inject 2u subq three times daily before meals, "Instructions: Pull cap and wipe with alcohol, place fresh needle on pen each time. Prime pen with 2 units and depress in sick/garbage. Dial up 2 units, pick injection site and clean with alcohol wipe. Push needle into skin and hold for 10 counts then remove. Place needle in sharps container (NEVER RECAP) always date the pen when new one is open (good for 28 days)." On April 14, 2026, at 8:31 a.m., unlicensed personnel (ULP)-B stated R2's blood glucose was checked prior to the surveyor's arrival which was 128. While sitting at a desk with the electronic medication administration record (eMAR) open, ULP-B set up R2's oral medications first then set R2's insulin lispro kwikpen to two (2) units and set Lantus Solostar pen to five (5) units. The surveyor was able to see the instructions on the eMAR indicating to prime the insulin pen prior to setting the dose. ULP-B did not prime either pen or wipe the rubber seal with alcohol wipe prior to place the needle. Both pens had been used prior to this administration. ULP-B then injected both insulins into R2's left lower quadrant of her abdomen near each other. On April 14, 2026, at 11:36 a.m., ULP-B set up R2's insulin lispro by placing a needle directly on the pen without wiping the rubber seal and dialed	01760		

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01760	Continued From page 25 the pen to 2 units without priming the pen. ULP-B injected the insulin into R2's right lower quadrant. ULP-B's employee record included a document titled Insulin Pen Medication Protocol with a Reusable Pen dated January 30, 2026, which included the following information: -use an alcohol wipe to clean the end of the pen where the needle will be attached; and -if required, prime the needle by following the manufacturer's instructions. ULP-B's employee record lacked training and competency evaluations for insulin administration. On April 14, 2026, at 12:55 p.m., the surveyor asked ULP-B if they were trained to prime the insulin prior to setting the dose, ULP-B did not know what the surveyor was referencing, so surveyor asked if they were trained to waste two units of insulin prior to dialing the dose, ULP-B stated no. On April 14, 2026, at 3:01 p.m., clinical nurse supervisor (CNS)-A stated she trained staff how to administer insulin by having ULP observe her completing the task which included priming the pen and shooting the insulin into the garbage. CNS-A was unaware ULP-B was not priming the pen prior to administration. The manufacturer's Lantus Solostar pen instructions dated August 2022, instructed the user to dial a test dose of 2 units, hold pen with needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. Press the injection button all the way in and check to see that insulin comes out of the needle.	01760		

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	41831	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE SENIOR LIVING LLC	5206 BRIGHTON LN MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 26 The manufacturer's Humalog Kwikpen (insulin lispro) instructions revised May 2025, instructed the user to prime the pen by dialing the pen to 2 units, point the needle up, tap the cartridge to bring any bubbles to the top, then push the button to release the insulin. The licensee's Staff Competency dated August 1, 2025, indicated training and competency evaluations for all ULP who administer medications as required. 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 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41831	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE SENIOR LIVING LLC	5206 BRIGHTON LN MOUNDS VIEW, MN 55112

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01940	Continued From page 27 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 develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2) receiving blood glucose monitoring. 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 was admitted to the licensee on September 23, 2025, and had diagnoses including diabetes mellitus, type II, schizoaffective disorder, paranoid type, and acute respiratory failure with hypoxia and hypercapnia. On April 14, 2026, at 8:31 a.m., unlicensed personnel (ULP)-B set up R2's oral medications	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41831	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01940	Continued From page 28 then stated they had already checked R2's blood glucose upon start of their shift and the result was 128. ULP-B then set up and administered a rapid-acting and long-acting insulin to R2 right before breakfast. R2's service plan agreement signed by R2 on March 30, 2025, indicated R2 received assistance with medication administration, blood glucose checks four (4) times daily, oxygen therapy, bathing, behavior management, and dressing/grooming. R2's signed prescriber orders dated March 30, 2026, included the following: -Record-Blood glucose: 4 times daily using blood glucose reader. Notify RN (registered nurse) if: If blood glucose is less than 70 or greater than 300 (this instruction was exactly indicated on R2's Service Recap Summary). R2's Service Recap Summary-Month dated April 2026, included the following: -Record blood glucose at AM, mid-day, PM, and bedtime and notify RN if: If blood glucose is less than 70 or greater than 300. On April 14, 2026, at 10:06 a.m., clinical nurse supervisor (CNS)-A and the surveyor observed on R2's electronic health record (Residex) the service description for checking blood glucose which instructed to check blood glucose before meals and report to nurse if below 70 or above 300. CNS-A confirmed the service description did not specify to check blood glucose finger poke or by using Freestyle Libre 2. CNS-A stated staff were trained to use the Freestyle Libre 2. On April 14, 2026, at 11:36 a.m., ULP-B met R2 alone in the living room where they administered	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41831	A. BUILDING: _____ B. WING _____	04/15/2026

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ASPIRE SENIOR LIVING LLC	5206 BRIGHTON LN MOUNDS VIEW, MN 55112

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01940	Continued From page 29 rapid-acting insulin. The surveyor observed R2's Freestyle Libre 2 sitting on the coffee table in front of R2. A few minutes later, CNS-A walked in and was asked who changed R2's sensor. CNS-A stated she either she or staff or did. CNS-A stated they had not been documenting that task, but just follow when the reader tells staff to change the sensor. CNS-A stated the sensor was typically changed every two weeks. R2's treatment and therapy management plan lacked identification of the type of blood glucose reader used and instructions on changing the sensor, who would be responsible for ordering/changing the sensor, and documentation of sensor changes. The FreeStyle Libre 2 Plus Sensor system usage guide dated 2025, indicated the sensor was designed to stay on for up to 15 days and to apply the new sensor to a different spot on the back of the arm to avoid skin irritation. The licensee's Treatment and Therapy Management policy dated August 1, 2025, indicated the RN or licensed professional would prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services which addresses: a. Type of service to be provided; b. Procedures for documenting treatments or therapies; c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; d. Identification of treatment or therapy tasks delegated to ULP; and e. Procedures for notifying the RN or licensed health professional when a problem arises related	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41831	A. BUILDING: _____ B. WING _____	04/15/2026

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01940	Continued From page 30 to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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

Aspire Senior Living LLC
5206 BRIGHTON LN
Mounds View, MN 55112
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41831

Risk:
License:
Expires on:
CFPM: Barlin Ahmed
CFPM #: 59673; Exp: 5/22/2028

Inspection Info

Report Number: F1025261085
Inspection Type: Full - Single
Date: 4/13/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

New Order: 4-300 Equipment Numbers and Capacities
4-301.12A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.
COMMENT: Facility dishwasher does not have an NSF 184 Residential sanitize cycle
https://www.frigidaire.com/en/p/kitchen/dishwashers/FDPC4221AS

Provide a dishwasher which has an NSF 184 certification. Send a link to this department to verify before dishwasher has the correct specs prior to purchase.

Until replaced, wash dishes and utensils in the dishwasher and then sanitize in a container large enough to immerse items and use a sanitizing solution (e.g. 1 gal water : 1 tea unscented chlorine bleach) using a test kit to verify concentration (chlorine 50-100 PPM).
https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf

Provide confirmation to this department when the unit is replaced via photo through email.
Comply By: 5/31/2026 Originally Issued On: 4/13/2026

Food & Beverage General Comment

Facility has residential finishes, 2 compartment sink, dishwasher

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discussed employee health and hygiene, food cooking and holding temperatures, cross-contamination, food storage order in refrigerator, separating resident food from medication or staff food, date marking TCS foods, food source and recalls

"MDA Food Recall" https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

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 F1025261085 from 4/13/2026

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@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

Aspire Senior Living LLC
Mounds View
County/Group: Hennepin County

Inspection Info

Report Number: F1025261085
Inspection Type: Full
Date: 4/13/2026
Time: 11:00 AM

Food Temperature: Product/Item/Unit: Mayo**; Temperature Process:** Cold holding
Location: Refrigerator door at 40 Degrees F.
Comment:
Violation Issued?: No

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

ASPIRE SENIOR LIVING LLC
5206 BRIGHTON LN
Mounds View, MN 55112
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41831

Risk:
License:
Expires on:
CFPM: Barlin Ahmed
CFPM #: 59673; Exp: 5/22/2028

Inspection Info

Report Number: F1025261087
Inspection Type: Follow-up - Single
Date: 4/16/2026 Time: 12:00 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

Received email with information for new dishwasher
GE #GDF550PGRWW
Specification information provided by licensee indicates the model does have an NSF 184 sanitize feature. Dishwasher to be purchased and installed.

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 F1025261087 from 4/16/2026

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@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

ASPIRE SENIOR LIVING LLC
Mounds View
County/Group: Hennepin County

Inspection Info

Report Number: F1025261087
Inspection Type: Follow-up
Date: 4/16/2026
Time: 12:00 PM

Food Temperature: Product/Item/Unit: Mayo**; Temperature Process:** Cold holding
Location: Refrigerator door at 40 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41831015-0	**Date:** 4/15/2026
Facility Name: ASPIRE SENIOR LIVING LLC	
Facility Address: 5206 BRIGHTON LN MOUNDS VIEW, MN 55112	

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type

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. Owner/house manager (O/HM)-E stated no resident policy was in place at the time of the survey.

3. 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/HM-E stated no resident training had taken place to date.