Electronically Delivered

March 17, 2026

Licensee
Dignity & Compassion Homes LLC
4986 Xylon Avenue North
New Hope, MN 55428

RE: Project Number(s) SL39932016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 19, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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. 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,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNITY & COMPASSION HOMES LLC	4986 XYLON AVENUE NORTH NEW HOPE, MN 55428

(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: SL39932016-0 On February 17, 2026, through February 19, 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 four residents; four receiving services under the 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 February 17, 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 included all required content for three of three employees (clinical nurse supervisor (CNS)-D, unlicensed personnel (ULP)-C, ULP-E). 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: CNS-D CNS-D was hired on October 23, 2023, to provide clinical oversite and assisted living services. CNS-D's employee record lacked documentation of the following topics: - overview of assisted living statutes; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - review of types of assisted living services the employee will provide and provider's scope of license. On February 19, 2026, at 12:08 p.m., CNS-D stated they believed the training topics had been completed. CNS-D stated that at the time of hire, they had completed a lot of training on paper, and it was possible documentation of the trainings were not maintained. ULP-C ULP-C was hired on August 6, 2024, to provide assisted living services. On February 18, 2026, from 7:39 a.m. to 9:15 a.m., the surveyor observed ULP-C provide morning medications and assisted living services to residents.	0 650		

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0 650	Continued From page 5 ULP-C's employee record lacked documentation of the following training topics: - overview of assisted living statutes; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - documentation requirements for all services provided; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - awareness of confidentiality and privacy; and - observation, reporting, and documenting of resident status. In addition, ULP-C's employee record lacked documentation of the following required competency testing: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting - standby assistance techniques and how to	0 650		

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0 650	Continued From page 6 perform them; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts) On February 18, 2026, at 12:12 p.m., ULP-C stated they recalled receiving the training missing from their training record. Additionally, ULP-C stated they also recalled receiving two hours of competency training and competency which was completed with the registered nurse. ULP-E ULP-E was hired on July 8, 2025, to provide assisted living services. On February 18, 2026, at 2:32 p.m., agent (A)-A stated ULP-E was a current and active employee who provided assisted living services to residents. ULP-E's employee record lacked documentation of the following required competency testing: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting - standby assistance techniques and how to perform them; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and	0 650		

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0 650	Continued From page 7 - other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On February 19, 2025, at 1:10 p.m., agent (A)-A stated they were unaware of the missing training records for staff. A-A stated they had used the document titled EduCare Assisted Living Orientation Checklist for the documentation of all required topics. A-A stated they were unaware that the document indicated that a copy of the staff's skills assessments would need to be attached to the form in order to demonstrate competency. The licensee's undated Employee Records policy indicated employee records must demonstrate compliance with the assisted living license and standards of care and must include records of orientation, required annual training, infection control training, and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660		

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0 660	Continued From page 8 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of symptom screening for two of three employees (unlicensed personnel (ULP)-C, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's facility TB risk assessment dated September 16, 2025, indicated the facility was low risk for TB transmission. ULP-C ULP-C was hired on August 6, 2024, to provide assisted living services.	0 660		

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0 660	Continued From page 9 On February 18, 2026, from 7:39 a.m. to 9:15 a.m., the surveyor observed ULP-C provide morning medications and assisted living services to residents. ULP-C's employee record contained a QuantiFERON-TB gold plus blood test dated July 30, 2024, which indicated negative results. ULP-C's employee record lacked documentation of a symptom screening. ULP-E ULP-E was hired on July 8, 2025, to provide assisted living services. On February 18, 2026, at 2:32 p.m., agent (A)-A stated ULP-E was a current and active employee who provided assisted living services to residents. ULP-E's employee record contained a QuantiFERON-TB gold plus blood test dated June 26, 2025, which indicated negative results. ULP-E's employee record lacked documentation of a symptom screening. On February 19, 2025, at 12:41 p.m., clinical nurse supervisor (CNS)-D stated they were responsible for completing TB symptom screening for staff and was aware of the requirements to complete symptom screening at the time of hire. CNS-D stated they thought it was been completed for ULP-C and ULP-E. The Minnesota Department of Health's, Regulations for Tuberculosis Control in Minnesota Health Care Settings, A guide for implementing tuberculosis (TB) infection control regulations in your facility, dated July 2013 indicated An employee may begin working with patients after a	0 660		

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0 660	Continued From page 10 negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative Interferon Gamma Release Assay (IGRA) or TST (i.e., first step) dated within 90 days before hire. The licensee's undated Tuberculosis Screening policy indicated each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. This includes, at a minimum, the health symptom screening, TB skin testing via the Mantoux method. This testing includes the pre-placement evaluation, administration and interpretation of TB Mantoux skin tests and periodic evaluation based on facility risk assessment or a negative IGRA (blood test). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following 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	0 680		

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0 680	Continued From page 11 (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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post the emergency plan prominently. 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 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: On February 17, 2026, at 1:48 p.m., the surveyor observed agent (A)-A retrieve the licensee's EPP from a locked medication cabinet. A-A stated the license typically stored the EPP within the locked medication cabinet.	0 680		

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	39932	A. BUILDING: _____ B. WING _____	02/19/2026

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0 680	Continued From page 12 The licensee's undated written emergency disaster preparedness plan lacked evidence of the following required content: - documentation of the annual review of the EPP; - documentation of the all hazards risk assessment; - inclusion of a process for collaboration with local, tribal, regional, state and federal Emergency Program (EP) to maintain integrated response; - development of EP policies and procedures based on the EP, risk assessment & communication plan; - policies and procedures to address subsistence needs for staff and patients; - policies and procedures to address the use of volunteers, including the process/role for integration; - inclusion of copies of arrangement agreements with other facilities; - policies and procedures to address the role of the facility under a waiver declared by the secretary in accordance with section 1135 of the Act; - development of a communication plan; - names and contact information of staff, entities providing services under agreement, residents' physicians, other facilities and volunteers; - emergency officials contact information; - primary and alternate means of communicating with facility staff and federal, state, tribal, regional & local emergency management agencies; - methods for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care; - policies and procedures on providing information about the facility's occupancy, needs, and its ability to provide assistance, to the	0 680		

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0 680	Continued From page 13 authority having jurisdiction, the incident command center, or designee, and; - policies and procedures on methods for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives. On February 19, 2026, at 1:16 p.m., agent (A)-A stated they had received the license's EPP from a consultant and was under the assumption that the document was fully developed and customized to their facility. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated June 13, 2023, indicated the licensee would have in place an effective and compliant Emergency Preparedness Plan. The policy indicated the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." 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 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	0 775		

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0 775	Continued From page 14 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 February 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 15 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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	0 780		

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0 780	Continued From page 16 Environment Inspection Report (PEIR) dated February 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=B	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; 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 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is	0 790		

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0 790	Continued From page 17 not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 810		

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0 810	Continued From page 18 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01620	Continued From page 19	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 20 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 a reassessment not to exceed 90 days for two of two residents (R2, R3). 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: R2 R2 was admitted on June 12, 2023, to receive assisted living services. R2's diagnoses included metabolic encephalopathy, alcohol dependence with withdrawal, schizophrenia, type 2 diabetes	01620		

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01620	Continued From page 21 mellitus, chronic viral hepatitis C, benign prostatic hyperplasia and hyperlipidemia. R2's service plan dated June 12, 2023, indicated R2 received assistance with activities of daily living (ADL), bathing, safety checks, grooming, behavior management, medication management, medication administration, shopping, transportation, housekeeping, laundry, blood glucose monitoring, and vital signs. On February 18, 2026, from 7:53 a.m. to 8:40 a.m., the surveyor observed R2 receive medication administration, treatments, and assistance with activities of daily living from unlicensed personnel (ULP)-C. R2's record contained a 90-day assessment dated June 22, 2025, with the next 90-day assessment occurring September 22, 2025, indicating 92 days had passed between assessment dates. R2's following assessment was dated December 22, 2025, indicating 92 days had lapsed between assessment dates. R3 R3 was admitted on May 11, 2024, to receive assisted living services. R3's diagnoses included Alzheimer's disease with late onset, schizoaffective disorder, major depressive disorder, essential hypertension, gastroesophageal reflux disease without esophagitis, hypercholesterolemia, and cerebral infarction without residual deficits. R3's record lacked documentation of a written service plan. R3's record contained a document titled Minnesota Department of Human Services Support Plan which indicated R3 received	01620		

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01620	Continued From page 22 assisted living services to include assistance with meals, scheduling appointments, socialization, dressing, grooming, bathing, eating, toileting, mobility, positioning, medication administration, and medication setup. On February 18, 2026, from 8:40 a.m. to 9:19 a.m., the surveyor observed R3 receive medication administration, treatments, and assistance with activities of daily living from ULP-C. R3's record contained a 90-day assessment dated August 13, 2025, with the next 90-day assessment occurring November 13, 2025, indicating 92 days had passed between assessment dates. R3's following assessment was dated February 13, 2026, indicating 92 days had lapsed between assessment dates. On February 19, 2025, at 12:10 p.m., clinical nurse supervisor (CNS)-D stated they had set up resident assessments to be completed every three months, and had been trying their best to ensure assessments were completed on time. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated on-going reassessment, and monitoring will be conducted as needed based on changes in the needs of the residents and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01640	Continued From page 23	01640		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement a written service plan for one of two residents (R3). 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	01640		

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01640	Continued From page 24 portion or all of the residents). The findings include: R3 was admitted on May 11, 2024, to receive assisted living services. R3's diagnoses included Alzheimer's disease with late onset, schizoaffective disorder, major depressive disorder, essential hypertension, gastroesophageal reflux disease without esophagitis, hypercholesterolemia, and cerebral infarction without residual deficits. R3's record lacked documentation of a written service plan. R3's record contained a document titled Minnesota Department of Human Services Support Plan which indicated R3 received assisted living services to include assistance with meals, scheduling appointments, socialization, dressing, grooming, bathing, eating, toileting, mobility, positioning, medication administration, and medication setup. On February 18, 2026, from 8:40 a.m. to 9:19 a.m., the surveyor observed R3 receive medication administration, treatments, and assistance with activities of daily living from ULP-C. On February 18, 2026, at 11:16 a.m., A-A stated R3 was admitted on waivered services and there had not been a service plan implemented for R3. A-A stated the same would be true for all other residents on waivered services. The licensee's undated Service Plan policy indicated assisted living services will be provided according to a suitable and current written service plan. The service plan, and any revisions must	01640		

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01640	Continued From page 25 include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. The Service Plan shall be signed by the resident or financially responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 face-to-face medication management re-assessments at least annually for two of two residents (R2, R3). 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	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNITY & COMPASSION HOMES LLC	4986 XYLON AVENUE NORTH NEW HOPE, MN 55428

(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
01710	Continued From page 26 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: R2 R2 was admitted on June 12, 2023, to receive assisted living services. R2's diagnoses included metabolic encephalopathy, alcohol dependence with withdrawal, schizophrenia, type 2 diabetes mellitus, chronic viral hepatitis C, benign prostatic hyperplasia, and hyperlipidemia. R2's service plan dated June 12, 2023, indicated R2 received assistance with activities of daily living (ADL), bathing, safety checks, grooming, behavior management, medication management, medication administration, shopping, transportation, housekeeping, laundry, blood glucose monitoring, and vital signs. On February 18, 2026, from 7:53 a.m. to 8:40 a.m., the surveyor observed R2 receive medication administration, treatments, and assistance with activities of daily living from unlicensed personnel (ULP)-C. R2's record contained a medication management plan dated June 12, 2023. This plan contained all required content of a medication management assessment. R2's record lacked documentation of an ongoing medication management assessment occurring on an annual basis. R2's record contained a 90-day assessment dated December 22, 2025, which was completed on a paper Uniform Assessment Tool. The	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01710	Continued From page 27 assessment form lacked the following required content of a medication management assessment: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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. R3 R3 was admitted on May 11, 2024, to receive assisted living services. R3's diagnoses included Alzheimer's disease with late onset, schizoaffective disorder, major depressive disorder, essential hypertension, gastroesophageal reflux disease without esophagitis, hypercholesterolemia, and cerebral infarction without residual deficits. R3's record lacked documentation of a written service plan. R3's record contained a document	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNITY & COMPASSION HOMES LLC	4986 XYLON AVENUE NORTH NEW HOPE, MN 55428

(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
01710	Continued From page 28 titled Minnesota Department of Human Services Support Plan which indicated R3 received assisted living services to include assistance with meals, scheduling appointments, socialization, dressing, grooming, bathing, eating, toileting, mobility, positioning, medication administration and medication setup. On February 18, 2026, from 8:40 a.m. to 9:19 a.m., the surveyor observed R3 receive medication administration, treatments, and assistance with activities of daily living from ULP-C. R3's record contained a medication management plan dated May 11, 2024. This plan contained all required content of a medication management assessment. R3's record lacked documentation of an ongoing medication management assessment occurring on an annual basis. R3's record contained a 90-day assessment dated February 13, 2026, which was completed on a paper Uniform Assessment tool. The assessment form lacked the following required content of a medication management assessment: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel;	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNITY & COMPASSION HOMES LLC	4986 XYLON AVENUE NORTH NEW HOPE, MN 55428

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01710	Continued From page 29 - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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. On February 19, 2026, at 12:18 p.m., clinical nurse supervisor (CNS)-D stated they were not aware the medication monitoring and reassessment needed to be done on an annual basis, but going forward they would ensure the assessments would be completed in conjunction with annual provider order renewals. The licensee's undated Medication Management Services policy indicated the RN would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines and will develop specific procedures for medication management services that staff will provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

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
01820	Continued From page 30 managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained 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). The findings include:: R2 was admitted on June 12, 2023, to receive assisted living services. R2's diagnoses included metabolic encephalopathy, alcohol dependence with withdrawal, schizophrenia, type 2 diabetes mellitus, chronic viral hepatitis C, benign prostatic hyperplasia, and hyperlipidemia. R2's service plan dated June 12, 2023, indicated R2 received assistance with activities of daily living (ADL), bathing, safety checks, grooming, behavior management, medication management, medication administration, shopping, transportation, housekeeping, laundry, blood glucose monitoring, and vital signs. R2's February medication administration record (MAR) indicated R2 received the following	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGNITY & COMPASSION HOMES LLC	4986 XYLON AVENUE NORTH NEW HOPE, MN 55428

(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
01820	Continued From page 31 medications: - folic acid 1000mcg: take 1 tablet by mouth daily; - ferrous sulfate 325mg EC tab: take 1 tablet by mouth daily with breakfast; - vitamin B-1 100mg tab: take 1 tablet by mouth daily; and - Lipitor 20mg tab: 1 tablet by mouth every night at bedtime. R2's record lacked documentation of signed physician orders. On February 19, 2026, at 11:50 a.m., agent (A)-A stated there were no signed physician orders on file for R2, but that they would ensure orders were obtained in the future. On February 19, 2026, at 12:21 p.m., clinical nurse supervisor (CNS)-D stated they would ensure the licensee obtains and maintains physician orders for all residents going forward. The licensee's undated Physician Orders Policy indicated the licensee would ensure all medical and health-related services are based on valid prescriber order, and that orders are current, legible, complete, and authenticated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

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01910	Continued From page 32 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 33 The findings include: R1 was discharged from the licensee on October 31, 2025. R1's record lacked documentation of disposition of R1's medications. On February 19, 2026, at 12:27 p.m., clinical nurse supervisor (CNS)-D stated that upon discharge, R1's medications were given to R1's son. CNS-D stated they were not aware of the required documentation for a medication disposition but would ensure documentation is completed for all future discharges. The licensee's undated Medication Disposition or Disposal policy indicate staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication, dose, and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

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01970	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving treatments. 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 on June 12, 2023, to receive assisted living services. R2's diagnoses included metabolic encephalopathy, alcohol dependence with withdrawal, schizophrenia, type 2 diabetes mellitus, chronic viral hepatitis C, benign prostatic hyperplasia, and hyperlipidemia. R2's service plan dated June 12, 2023, indicated R2 received assistance with activities of daily living (ADL), bathing, safety checks, grooming, behavior management, medication management, medication administration, shopping, transportation, housekeeping, laundry, blood glucose monitoring, and vital signs. R2's February medication administration record (MAR) indicated R2 received the following	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39932	A. BUILDING: _____ B. WING _____	02/19/2026

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DIGNITY & COMPASSION HOMES LLC	4986 XYLON AVENUE NORTH NEW HOPE, MN 55428

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01970	Continued From page 35 treatment: - One touch ultra test strips: test once daily; and - One touch del plus 33G mis: use to test blood sugar one time daily. On February 18, 2026, at 8:31 a.m., the surveyor observed unlicensed personnel (ULP)-C obtain a blood glucose check on R2. R2's record lacked documentation of signed physician orders for blood glucose monitoring provided by the licensee. On February 19, 2026, at 11:50 a.m., agent (A)-A stated there were no signed physician orders on file for R2, but that they would ensure orders were obtained in the future. The licensee's undated Treatment and Therapy Management Plan policy indicated orders must be obtained for medications, treatments or therapies that would require orders from an authorized provider before the services are provided No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R4) with oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 17, 2026, at 11:02 a.m., during a tour of the facility, the surveyor observed an oxygen tank in room #3 of the facility. The oxygen tank was sitting on end upright directly behind the bedroom door. The oxygen tank had a plastic tag attached to the valve indicating the tank was full. On February 19, 2026, at 1:20 a.m., agent (A)-A stated the oxygen tank belonged to R4. A-A stated R4 had recently been transferred to the hospital with their portable cart and tank. A-A stated the tank found in the room had been delivered after R4 was sent to the hospital, and due to R4's storage cart being brought to the hospital, the licensee had no cart available to provide appropriate storage of oxygen tanks. A-A stated they had been in communication with the oxygen supply company for appropriate storage options. The licensee's undated Safe Oxygen Use and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 37 Storage policy indicated the facility staff will ensure that the resident has an appropriate storage cart or stand for the oxygen cylinder or oxygen concentrator. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

Dignity and Compassion Homes
4986 Xylon Avenue North
New Hope, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: 0042470

Risk:
License: -1
Expires on: 12/31/2024
CFPM: Augusta White
CFPM #: FM116596; Exp: 04/27/2026

Inspection Info

Report Number: F1047261045
Inspection Type: Full - Single
Date: 2/17/2026 Time: 12:00 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG AVAILABLE ON SITE. SAMPLE LOG PROVIDED WITH REPORT.
Comply By: 2/17/2026 Originally Issued On: 2/17/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: FACILITY STATED THEY USE A CHLORINE SANITIZER SOLUTION TO STORE THEIR WIPING CLOTHS/CLEAN THEIR KITCHEN BUT THEY DID NOT HAVE AVAILABLE TEST STRIPS
Comply By: 2/17/2026 Originally Issued On: 2/17/2026

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator Z. Morth

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 F1047261045 from 2/17/2026

Holly Green

_____ _____

Augusta White
Operator

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@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

Dignity and Compassion Homes
New Hope
County/Group: Hennepin County

Inspection Info

Report Number: F1047261045
Inspection Type: Full
Date: 2/17/2026
Time: 12:00 pm

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 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

Dignity and Compassion Homes
New Hope
County/Group: Hennepin County

Inspection Info

Report Number: F1047261045
Inspection Type: Full
Date: 2/17/2026
Time: 12:00 pm

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 159 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39932016	**Date:** 2/18/2026
Facility Name: Dignity and Compassion Homes	
Facility Address: 4986 Xylon Ave N., Minneapolis, MN 55428	

☒ **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. *Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]*

   Comments: The dryer vent was completely disconnected from the clothes dryer and lint had accumulated behind the dryer. The lint should be removed, and the dryer should be reconnected properly and ventilation maintained in proper condition.

3. *Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]*

   Comments: An unapproved multiplug adapter was in use in the living room to power multiple electronics.

4. *Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]*

   Comments: An extension cord was in use in resident room 1 powering multiple electronics. Extension cords should not be used in lieu of permanent wiring.

☒ **TAG IDENTIFICATION: 0780**

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

1. Listed single- and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

   Comments: Many of the smoke alarm devices provided throughout the facility did not display any indication they were listed to underwriter laborites (UL) standards to comply with requirements. Agent (A)-A was unable to provide user manuals or UL listing information to the surveyor during the survey. The online user manual for the smoke alarm model provided did not indicate proper listing to UL standards. No further information was provided to the surveyor, and the requirements for smoke alarms could not be verified

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

   Comments: There were two separate systems of smoke alarms provided throughout the facility. Hardwired smoke alarms throughout the facility did not interconnect with the wireless alarm system provided throughout the facility. All alarms in the facility must be interconnected such that the activation of any one alarm causes all other alarms to sound. The hardwired alarms must be maintained as hardwired.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: The extinguisher provided in the kitchen of the facility was not properly mounted and was stored on the ground to the side of the garbage can which made it difficult to locate and access. Extinguishers should be properly mounted and maintained so they are accessible in an emergency.

☒ **TAG IDENTIFICATION: 0810**

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

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1. *Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]*

   Comments: The FSEP was stored in a locked cabinet near the living room. A copy of the FSEP should be provided readily accessible and not locked up.

2. 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 did not include any copies or documentation of facility maps or other information detailing the location and number of resident rooms. Several different and conflicting versions of floor plans were hung on the facility walls. Accurate facility maps should be included in the FSEP.

3. *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 included general fire safety actions, but the actions were not accurate to the specific facility and were also not specific. The FSEP should be specific and developed with specifics for the particular facility.

4. *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: No specific unique resident needs for evacuation were provided. A template was included in the FSEP but was not accurate to the residents within the facility.

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: The FSEP did not include any documentation of annual resident trainings. Residents only received training at admission to the facility based on staff interview. Residents should be offered training at least once per year.