



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 3, 2025

Licensee

Living Hope Homes Cottage Crest
140 East Spruce Street
S St Paul, MN 55075

RE: Project Number(s) SL38292016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 19, 2025, 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 . . ."

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

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>

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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES COTTAGE CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST SPRUCE STREET S ST PAUL, MN 55075		
(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: SL38292016-0 On August 18, 2025, through August 19, 2025, the Minnesota Department of Health conducted a change of ownership survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; four receiving services under the provider's Assisted Living 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			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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,	0 480			

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 August 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480			

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content	0 680			

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0 680	Continued From page 4 as defined in Appendix Z. This had the potential to affect all five residents receiving services under the assisted living facility license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee's Emergency Preparedness Procedures binder last reviewed July 10, 2025, lacked the following required content: - an all-hazards risk assessment On August 19, 2025, at 3:47 p.m., licensed assistant living director (LALD)-A stated the licensee lacked a customized emergency preparedness plan and Appendix Z which included the above content. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated February 1, 2025, indicated: [Licensee name] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: 1. Risk assessment and planning 2. Policies and procedures	0 680			

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0 680	Continued From page 5 3. A communication plan 4. Staff training and exercises/drills [Licensee name] utilized a hazard vulnerability analysis tool to measure threats and hazards of concern, probability of events, measurements regarding the context of impact on people, property, and business, preparedness, and mitigation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=E	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 and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code under Minnesota Rule Chapter 7511. The deficient condition has the ability to affect all staff and residents. 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).	0 775			

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0 775	Continued From page 6 The findings include: On a facility tour on August 19, 2025, between 11:00 a.m. and 12:30 p.m. with the licensed as-sisted living director (LALD)-A, the surveyor observed the following conditions: RESIDENT ROOM EMERGENCY ESCAPE WINDOWS: The surveyor observed that the emergency escape and rescue openings were blocked in resident room 2 and 5. Resident room 2 had plants and decorations on the windowsill and resident room 5 had a stand-up storage cabinet blocking the emergency escape and rescue opening. At least one compliant emergency escape and rescue opening is required within each resident sleeping room. These openings shall always be accessible and usable. The deficient conditions were visually verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 810 SS=C	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	0 810			

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0 810	Continued From page 7 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide a mode of transportation in the event of an evacuation. No memorandum of understanding has been agreed upon and signed.	0 810			

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0 810	Continued From page 8 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 the potential to affect a large portion or all the residents). The findings include: A record review and interview were conducted on August 19, 2025, at approximately 12:00 p.m. with the licensed assisted living director (LALD)-A on the fire safety and evacuation plan. TRANSPORTATION: The LALD-A confirmed that they had not entered into an agreement for transportation if the facility was needed to evacuate. The LALD-A stated that they would use emergency services. The facility shall have a memorandum of understanding with a transportation company and have a signed agreement onsite or identify/provide a way to transport their residents if an evacuation is needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500			

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01500	Continued From page 9 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500			

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01500	Continued From page 10 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel/site supervisor (ULP/SS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ULP/SS-C was hired on July 31, 2023, to provide direct care services under the licensee's assisted living license. On August 19, 2025, at 7:52 a.m., the surveyor observed ULP/SS-C administering medications to R3.	01500			

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01500	Continued From page 11 ULP/SS-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection to those rights; and - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On August 19, 2025, at 2:38 p.m., licensed assisted living director (LALD)-A reviewed ULP/SS-C's employee record and stated being unable to find evidence the above annual training had been completed as required. LALD-A further stated not realizing the assisted living bill of rights training was required annually and was only assigning this training upon hire. The licensee's 5.06 Annual Required Staff Training policy dated February 1, 2025, indicated: The following training elements MUST be included every 12 months to all staff who performs direct care services: 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			

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01620	Continued From page 12	01620			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES COTTAGE CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST SPRUCE STREET S ST PAUL, MN 55075			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 13 review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a resident assessment within 14 days of admission for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the facility on May 7, 2025, with diagnoses including generalized weakness, type II diabetes, hypertension (high blood pressure), and history of traumatic brain injury (TBI). R1's Service Plan (Waiver) - Addendum to	01620			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES COTTAGE CREST			STREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST SPRUCE STREET S ST PAUL, MN 55075		
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01620	Continued From page 14 Contract dated June 30, 2025, indicated R1 received services including assistance with bathing, dressing, grooming, transfers, toileting, escorts/mobility assistance, compression stockings, medication administration, blood glucose checks, CPAP (continuous positive airway pressure) machine, behavior monitoring, housekeeping, and laundry. R1's record included an admission assessment dated May 7, 2025, and a 14-day assessment dated May 22, 2025. 15 days had passed between the admission assessment/start of services, and the 14-day assessment (one day late). On August 19, 2025, at 8:46 a.m., clinical nurse supervisor (CNS)-B reviewed R1's record and stated the 14-day assessment had been completed late. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated February 1, 2025, indicated: 3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES COTTAGE CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST SPRUCE STREET S ST PAUL, MN 55075			
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01940	Continued From page 15 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 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 (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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES COTTAGE CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST SPRUCE STREET S ST PAUL, MN 55075			
(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 16 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: During the entrance conference on August 18, 2025, at 12:28 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to the licensee's residents. On August 19, 2025, at 8:38 a.m., the surveyor observed R1 seated in a wheelchair at the dining room table with bilateral Farrow wraps (compression wraps with Velcro closure) on his lower legs. R1's diagnoses included type II diabetes and hypertension (high blood pressure). R1's Service Plan (Waiver) - Addendum to Contract dated June 30, 2025, indicated R1 received services including assistance with compression stockings. R1's prescriber order signed February 27, 2025, indicated the following: - Please order pair of Farrow wraps, including premium ankle foot wrap. No open venous stasis ulcers present. 30-40 mmHg (refers to pressure level of compression garment) required. R1's Service Recap Summary dated August 2025, included documentation for application of the Farrow wraps.	01940			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES COTTAGE CREST		STREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST SPRUCE STREET S ST PAUL, MN 55075			
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01940	Continued From page 17 R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On August 19, 2025, at 2:38 p.m., clinical nurse supervisor (CNS)-B reviewed R1's record and stated there were no directions for unlicensed staff on when to contact a nurse with issues for R1's compression stockings/Farrow wraps. The licensee's 7.05 Treatment & Therapy Management Plan policy dated February 1, 2025, indicated: 1. [Licensee name] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. 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

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Establishment Info

LIVING HOPE HOMES COTTAGE CRES
140 EAST SPRUCE STREET
South St Paul, MN 55075
Dakota County
Parcel:

Phone:
kelli.dixon@livinghopehomes.com

License Info

License: HFID 38292

Risk:
License:
Expires on:
CFPM: Kelli Dixon
CFPM #: 120598; Exp: 11/6/2026

Inspection Info

Report Number: F1031251088
Inspection Type: Full - Single
Date: 8/18/2025 Time: 12pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT:

STAFF DID NOT SUBMIT DISH MACHINE TEMP.

STAFF TO CHECK TEMP IS 160F OR GREATER AND REPORT TO INSPECTOR ASAP.

Comply By: 8/18/2025 Originally Issued On: 8/18/2025

! New Order: 7-200 Toxic Supplies and Applications

7-204.11 Priority Level: Priority 1 CFP#: 28

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT:

CHEMICAL WIPES USED FOR FOOD CONTACT SURFACES MEASURED > 400PPM.

DISCONTINUE USING PREMADE WIPES AND SPRAY CHEMICALS ON FOOD CONTACT SURFACES.

MAKE BLEACH AND WATER SPRAY AND TEST FOR CONCENTRATION (50-200PPM).

Comply By: Complied On Site Originally Issued On: 8/18/2025

Food & Beverage General Comment

All violations discussed with PIC prior to leaving site.

Discussed:

- Cooling and reheating not allowed
- 100% cooking of all raw meats
- Raw items storage'
- Thawing
- Pasteurized egg use
- Pests
- Illness and illness log

ILLNESS COMPLAINT PROCEDURE:

If any customer complains of illness take these steps:

1. Gather as much information from the customer as possible, such as: name, phone#, date of illness, food consumed.
2. Give customer the illness hotline phone number: 1-877-366-3455.
3. Contact your health inspector: Give inspector information gathered from customer and any other useful information.

Contact inspector prior to any major equipment or building changes; some changes may require plan review to be completed.

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 F1031251088 from 8/18/2025



Kelli Dixon
CFPM

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
LIVING HOPE HOMES COTTAGE CRES	Report Number: F1031251088
South St Paul	Inspection Type: Full
County/Group: Dakota County	Date: 8/18/2025
	Time: 12pm

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

LIVING HOPE HOMES COTTAGE CRES
South St Paul
County/Group: Dakota County

Inspection Info

Report Number: F1031251088
Inspection Type: Full
Date: 8/18/2025
Time: 12pm

Sanitizing Chemical: Product: Clorox Wipes ; **Sanitizing Process:** Sanitizing Wipes

Location: Kitchen **Greater Than** 400 PPM

Comment:

Violation Issued?: Yes

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** ?? Degrees F.

Comment: CFPM to send pic of irreversible thermometer ASAP

Violation Issued?: No

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Spray Bottle

Location: Kitchen **Equal To** 50 PPM

Comment: Make sani spray twice weekly (50-200ppm Chlorine)

Violation Issued?: No