Electronically Delivered

May 11, 2026

Licensee
Bestlife Healthcare Services LLC
109 9th Avenue Northeast
Osseo, MN 55369

RE: Project Number(s) SL39855016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 15, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

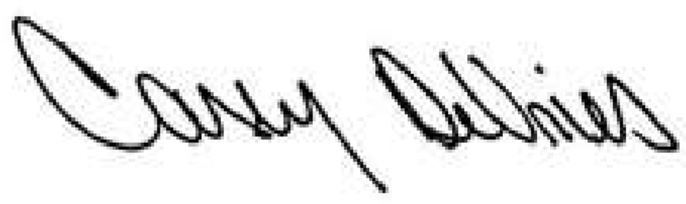
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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
	39855	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BESTLIFE HEALTHCARE SERVICES LLC	109 9TH AVENUE NORTHEAST OSSEO, MN 55369

(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: SL39855016-0 On April 13, 2026, through April 15, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents, all of whom received 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.	
0 115 SS=D	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	0 115		

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0 115	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain an assisted living with dementia care license (ALFDC). The facility was secured, and one of four residents (R3) was not able to leave the building without staff assistance. 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: R3 was admitted to the licensee on September 22, 2025, and began receiving assisted living services. R3's diagnoses included intercranial injury with	0 115		

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0 115	Continued From page 2 loss of consciousness and gastroesophageal reflux disease (GERD). R3's Service Plan signed with the contract on September 22, 2025, did not include services R3 would receive from the licensee. R3's Ursing (sic) Care Plan dated September 25, 2025, indicated R3 received assistance with behavior management, activities, bathing reminders, grooming, dressing, meals, toileting, transfers and positioning, laundry, housekeeping, vital sign monitoring, transportation, and medication administration. R3's admission assessment dated September 9, 2025, indicated R3 had a history of dementia, was orientated, forgetful, and wandered. R3's 14-day assessment dated October 7, 2025, indicated R3 showed signs of increased confusion and had a history of elopement. In addition, hourly checks were being performed to prevent elopement. On April 13, 2026, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had alarms on every exit door at the facility and the front door, and the garage door required an access code to exit. LALD/CNS-C stated all residents with the exception of R3 knew how to use the code on the doors to exit the facility. LALD/CNS-C stated R3 had a history of elopement and that was why the front door and garage door required codes to exit. On April 13, 2026, at approximately 10:10 a.m., during a facility tour, the surveyor observed the garage door lock and the front door lock. The	0 115		

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0 115	Continued From page 3 surveyor observed both doors had two locking mechanisms which included a top punch pad with a door lever and a lower round door handle with a lock. The top locking mechanism required an access code to be punched in, and after the code was punched in you would need to turn the lever at the same time you turned the round lower door handle in order to exit the facility. On April 14, 2026, at 8:45 a.m., the surveyor observed R3 attempting to open the front door however, they were unable to. On April 14, 2026, at 8:49 a.m., housing manager (HM)-A stated they believed the door locks were installed around October 2025. HM-A stated they were installed because R3's sister told the licensee they had a history of elopement and would walk out of places. HM-A stated "we try to keep him, so we don't have to go looking for him. That way we know where he is going if he leaves the facility." HM-A stated all other residents knew how to use the locks and were able to exit the facility without staff assistance. On April 14, 2026, at 11:12 a.m., LALD/CNS-C stated the doors have codes in order to exit the facility and alarms for when the doors open. LALD/CNS-C stated prior to the previous survey the licensee added alarms to the doors due to a previous resident who was at risk of elopement. LALD/CNS-C stated the new coded door lock was added after R3's admission because the alarm did not detour R3 from exiting the facility. LALD/CNS-C stated R3 did not know how to use the code to exit the facility. LALD/CNS-C stated they did not feel it restricted him from being able to go anywhere. LALD/CNS-C stated in an emergency staff would assist R3 out of the facility. LALD/CNS-C stated R3 was at risk for	0 115		

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0 115	Continued From page 4 elopement. The surveyor inquired if they had documentation to why the door locks were added to the facility doors. LALD/CNS-C stated they did not have any documentation. LALD/CNS-C stated they do not want to be licensed as an ALFDC and would remove the locks. On April 14, 2026, at 2:12 p.m., the surveyor observed the top locking mechanism on both doors removed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 115		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced	0 485		

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0 485	Continued From page 5 by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to pay for meals as a part of their assisted living package fee for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on February 13, 2026, and began receiving assisted living services. R3 was admitted to the licensee on September 22, 2025, and began receiving assisted living services. R2, and R3's Assisted Living Contract signed February 13, 2026, and September 22, 2025, respectively, included the following statement, "Subject to the Resident's needs, [the licensee] will provide the following services which are included in the basic monthly fee" 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [the licensee] staff at the following times: 6:00 AM - 8:00 AM Breakfast 11:30 AM - 12:30 PM Lunch 4:30 PM - 5:30 PM Dinner Snack"	0 485		

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0 485	Continued From page 6 The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee and lacked the option to opt out of the meal plan. On April 14, 2026, at 11:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were aware the contract could not include meals as part of their base fee. LALD/CNS-C stated they believed the contract only showed services that would be provided to residents as required by state regulation. LALD/CNS-C stated they did not see the wording that it was included in the base fee. LALD/CNS-C stated they bought the contract from a home care company and the company included that language in the contract. LALD/CNS-C stated all residents who resided in the facility used the same contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and	0 640		

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0 640	Continued From page 7 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 13, 2026, at approximately 9:55 a.m., during a facility tour, the surveyor observed a cordless telephone on a docking station in the upstairs living room of the facility. The surveyor observed no 911 emergency number posted near the telephone. On April 14, 2026, at 10:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the telephone in the living room was for public use. LALD/CNS-C stated they had written on the back of the telephone in case of an emergency dial 911 however, they believed someone removed the information. The licensee's undated 1.19 Emergency / 911	0 640		

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0 640	Continued From page 8 policy did not address posting the 911 number near telephones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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 interview and record review, the licensee failed to ensure employee records	0 650		

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0 650	Continued From page 9 included all required content for three of three employees (housing manger (HM)-A, unlicensed personnel (ULP)-B, 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 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: HM-A was hired to the licensee on July 5, 2023, to provide oversite of day-to-day operations and to provide assisted living services to residents. ULP-B was hired on July 24, 2024, to provide assisted living services to residents. ULP-E was hired on February 13, 2026, to provide assisted living services to residents. HM-A, ULP-B, and ULP-E's personnel file lacked training and competency evaluations for oral care and unplanned time away from home. On April 14, 2026, at 8:53 a.m., HM-A stated they received training and completed a return demonstration with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C on the topics listed above. On April 14, 2026, at 11:01 a.m., LALD/CNS-C verified HM-A, ULP-B, and ULP-E's records lacked the content listed above. LALD/CNS-C stated the above topics were part of the	0 650		

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0 650	Continued From page 10 licensee's orientation process. LALD/CNS-C stated their process was to complete training in an in-person class, have the ULP complete a return demonstration, and then fill out all of the paperwork at the end of the training day. LALD/CNS-C stated HM-A, ULP-B, and ULP-E received the training and completed the competency evaluations however, they forgot to document them. The licensee's Personnel Record policy dated August 1, 2021, indicated the personnel file would include documentation of orientation, annual training, supervision, and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BESTLIFE HEALTHCARE SERVICES LLC	109 9TH AVENUE NORTHEAST OSSEO, MN 55369

(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
0 680	Continued From page 11 (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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP titled Emergency Preparedness lacked evidence of the following required content: - annual review; - strategies for addressing facility and community-based risks which included staffing surges and shortages; - quarterly missing resident plan review; - substance needs for staff and residents;	0 680		

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0 680	Continued From page 12 - policies and procedures for evacuation which included transportation and alternative evacuation site; - policies and procedures for volunteers; - arrangement agreements with primary evacuation site; and - roles under a waiver declared by secretary. On April 14, 2026, at 11:30 a.m., during an interview with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C, owner/food safety manager (O/FSM)-D, and housing manager (HM)-A, HM-A stated they knew the EPP was reviewed in the last year however, they did not believe they documented the review. LALD/CNS-C confirmed they did not have documentation of when the review of the EPP occurred. HM-A stated the licensee planned on using their two on call workers if there was a staffing shortage however, they did not have that documented. CNS-C stated they reviewed the missing resident plan yearly however, they did not have documentation of the review. LALD/CNS-C stated if an evacuation was needed the residents would evacuate with use of their company vehicle and would evacuate to another one of their facilities or to a hotel. LALD/CNS-C stated they did not have documentation that the licensee would use their vehicle for transport. LALD/CNS-C stated they had not updated the EPP to indicate the new location to evacuate to however, the location they would evacuate to was written in the resident record. O/FMS-D stated they did not have an agreement with the hotel because they were focused on evacuating to their new location if they needed to. LALD/CNS-C, O/FMS-D, and HM-A all stated they did not know what a waiver declared by secretary was. The surveyor reviewed the waivers declared by secretary with them, and they all verified they did	0 680		

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0 680	Continued From page 13 not address this in the EPP. The licensee's Emergency Preparedness* policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain resident records with entries that were legible, permanently recorded, and accurately dated for one of three 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	0 690		

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0 690	Continued From page 14 situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on February 13, 2026, and began receiving assisted living services. On April 14, 2026, at 11:58 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee's service plan was comprised of two documents. The two documents were the care plan which showed the services provided to the resident, and a document titled Rate Sheet Agreement. R2's Rate Sheet Agreement was signed February 6, 2026. R2's Home Health Aide Care Plan, indicated R2 received assistance with set up of dressing, bathing and oral care reminders, as needed assistance with toileting, transfers, meals, medication administration, vital sign monitoring, blood glucose monitoring, behavior management, housekeeping, and laundry. Where the document was dated it showed 02/06/26, however the middle portion was written over to show the date of 02/13/26. R2's Resident Evaluation included a date line next to the signature line at the bottom of the assessment. The date line showed a bolded "13" over the top an unknown number to indicate the date of February 13, 2026. At the top of the assessment, it indicated the assessment was reviewed and the date written showed 2/24/26, however the middle portion was written over to show the date of 2/27/2026.	0 690		

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0 690	Continued From page 15 R2's Diabetic Flow Sheet dated April 2026, included a non-legible blood glucose reading on April 2, 2026, at 12:00 p.m., and April 6, 2026, at 12:00 p.m. R2's Braden Risk Assessment Scale included a date line next to the signature line at the bottom of the assessment. The date line showed an unknown number written in the day section of the date with a bolded "13" written over the top to indicate the date of February 13, 2026. R2's Home Health Aide Care Plan where it was dated showed 02/06/26 with the middle portion written over to show the date of 02/13/26. R2's Individual Abuse Prevention Plan Assessment included a date line next to the signature line at the bottom of the assessment. The date line showed an unknown number written in the day section of the date with a bolded "13" written over the top to indicate the date of February 13, 2026. R2's Individualized Treatment or Therapy Management Plan included R2's birthdate. The surveyor was unable to determine if the date showed 2/05/1966 or 2/25/1966. On April 15, 2026, at 9:45 a.m., LALD/CNS-C stated they misdated the Rate Sheet Agreement, and it should have been dated February 13, 2026. The surveyor inquired why the care plan initially was marked February 6, 2026, and then the 06 was written over to be 13. LALD/CNS-C stated R2 was supposed to be admitted on February 6, 2026. LALD/CNS-C stated R2 came into the facility and dropped off their belongings however, R2 did not stay at the facility until February 13, 2026. LALD/CNS-C stated it was their mistake	0 690		

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0 690	Continued From page 16 that the documents were dated February 6, 2026, but it was because that was the date that they had stuck in their head since that was supposed to be R2's admission date. LALD/CNS-C stated they noticed the incorrect date on the care plan and wrote over the date. The licensee's Clinical Record policy dated August 1, 2021, indicated all entries into the clinical record would be legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry. Ostendorf, P.A.P.A.G.P.P.A.S.A.H.W. R. (2025). Fundamentals of Nursing (12th ed.). Elsevier Health Sciences (US). https://bookshelf.vitalsource.com/books/9780443245336 Section 26. Informatics and documentation, page 392, Table 26.1, Legal Guidelines for Documentation indicated if your agency used paper documentation, only use black pen with legible handwriting. Do not erase, apply correction fluid, or scratch out errors made while documenting in a paper record. Draw a single line through the error, write the word error above it, and sign your name or initials. Then document note correctly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 775 SS=I	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:	0 775		

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0 775	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 14, 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;	0 780		

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0 780	Continued From page 18 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (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).	0 780		

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0 780	Continued From page 19 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. 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	0 800		

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0 800	Continued From page 20 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 21 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 14, 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 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 review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 23 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 reassessment no more than 14 calendar days after initiation of services for one of three residents (R3) and failed to complete ongoing resident reassessments that did not exceed 90 days for one of three 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 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: R3 was admitted to the licensee on September 22, 2025, and began receiving assisted living services. R3's diagnoses included intercranial injury with	01620		

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01620	Continued From page 24 loss of consciousness and gastroesophageal reflux disease (GERD). R3's Service Plan signed with the contract on September 22, 2025, did not include services R3 would receive. R3's Ursing (sic) Care Plan dated September 25, 2025, indicated R3 received assistance with behavior management, activities, bathing reminders, grooming, dressing, meals, toileting, transfers and positioning, laundry, housekeeping, vital sign monitoring, transportation, and medication administration. R3's record included an admission assessment completed September 22, 2025, a 14-day assessment completed October 7, 2025, and an ongoing 90-day assessment completed January 6, 2026, which indicated the 14-day assessment was completed 15 days after admission and the ongoing assessment was completed 92 days after the assessment completed on October 7, 2025. On April 14, 2025, at 11:45 a.m., during an interview with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C and owner/food safety manager (O/FSM)-D, LALD/CNS-C stated assessments were completed upon admission, day 14, ongoing every 90 days, and with change of condition like a hospital stay. The surveyor inquired why R3's assessments were late. LALD/CNS-C stated they were not sure why they were late and believed it could be because it fell on a weekend, or they came in to complete the assessment, but the resident was not available. O/FSM-D stated R3 required persuasion in order to complete tasks and that was why they believed it was late. The	01620		

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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
01620	Continued From page 25 surveyor asked if they had documentation to show why the assessments listed above were late. LALD/CNS-C stated no. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the RN would provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. In addition, ongoing resident reassessment must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39855	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BESTLIFE HEALTHCARE SERVICES LLC	109 9TH AVENUE NORTHEAST OSSEO, MN 55369

(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
01650	Continued From page 26 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for one of three 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 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: R3 was admitted to the licensee on September 22, 2025, and began receiving assisted living services. R3's diagnoses included intercranial injury with loss of consciousness and gastroesophageal reflux disease (GERD). R3's Ursing (sic) Care Plan dated September 25, 2025, indicated R3 received assistance with	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39855	A. BUILDING: _____ B. WING _____	04/15/2026

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BESTLIFE HEALTHCARE SERVICES LLC	109 9TH AVENUE NORTHEAST OSSEO, MN 55369

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01650	Continued From page 27 behavior management, activities, bathing reminders, grooming, dressing, meals, toileting, transfers and positioning, laundry, housekeeping, vital sign monitoring, transportation, and medication administration. The document indicated that R3's family refused to sign the care plan and included licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C's signature. It also indicated it was reviewed two times by LALD/CNS-C, however, did not have a place for family to be able to sign after the initial signature. R3's Service Plan signed with the contract on September 22, 2025, lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On April 14, 2026, at 11:58 a.m., LALD/CNS-C stated the licensee's service plan was comprised	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39855	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BESTLIFE HEALTHCARE SERVICES LLC	109 9TH AVENUE NORTHEAST OSSEO, MN 55369

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01650	Continued From page 28 of two documents. The two documents were the care plan which showed the services provided to the residents, and a document titled Rate Sheet Agreement. LALD/CNS-C stated they did not use the addendum to the contract service plan. LALD/CNS-C verified R3's record only included the contract addendum service plan and stated they believed someone removed the Rate Sheet Agreement from R3's record and did not put it back in the chart. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include the following: - a description of the services to be provided and the description may be in the form of the residents care plan developed with the responsible party; - fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; - the identification of the staff or categories of staff who would provide the services; - the schedule and methods of monitoring reviews or assessments of the resident; - the schedule and method of monitoring staff providing services; and - a contingency plan that included the following: - action to be taken if the scheduled service could not be provided; - information and method for a resident or resident's representative to contact the facility; - names and contact information of people the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition; - the identification of and information as to who has the authority to sign for the resident in an emergency; - circumstances in which emergency medical	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39855	A. BUILDING: _____ B. WING _____	04/15/2026

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BESTLIFE HEALTHCARE SERVICES LLC	109 9TH AVENUE NORTHEAST OSSEO, MN 55369

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01650	Continued From page 29 services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time sensitive medications once opened for one of four 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 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: On April 13, 2026, at 11:20 a.m., the surveyor	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39855	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BESTLIFE HEALTHCARE SERVICES LLC	109 9TH AVENUE NORTHEAST OSSEO, MN 55369

(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
01890	Continued From page 30 observed the licensee's locked medication cabinet and observed two bottles of timolol 0.5 percent (%) eye drops opened without a date open label for R3. On April 14, 2026, at 11:58 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated unlicensed personnel (ULP) were trained to label eye drops once opened. LALD/CNS-C stated they did not know why the two bottles of timolol listed above were not dated once opened. The manufacturer's instructions for timolol maleate ophthalmic solution dated February 2020 indicated once timolol maleate was opened it should be discarded in 28 days. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated medication was labeled completely and legibly and the medication label should contain the expiration date for time dated drugs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Bestlife Healthcare Services L
109 9th Avenue Northeast
Osseo, MN 55369
Hennepin County
Parcel:

Phone: 6125941861

License Info

License: 0042553

Risk:
License: -1
Expires on: 12/31/2024
CFPM: ESAU JASPER JR.
CFPM #: FM122167; Exp: 03/29/2027

Inspection Info

Report Number: F8087261081
Inspection Type: Full - Single
Date: 4/14/2026 Time: 4:00:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: KNOCKDOWN, ROUGH, APPEARS TO BE DURABLE - NON-COMPLIANT
FLOORS: TILE - COMPLIANT
COUNTERTOPS: QUART - COMPLIANT
CABINETS: WOOD - NON COMPLIANT
REFRIGERATOR/FREEZER: WHIRLPOOL
DISHWASHER: KENMORE
STOVE/RANGE: BOSCH
MICROWAVE: WHIRLPOOL
HAND WASHING SINK: YES - RIGHT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

NON COMPLIANT CEILING AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE PUCK USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR ASHLEY CREWS.

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 F8087261081 from 4/14/2026

John Boettcher

ESAU JASPER JR.
MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@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

Bestlife Healthcare Services L
Osseo
County/Group: Hennepin County

Inspection Info

Report Number: F8087261081
Inspection Type: Full
Date: 4/14/2026
Time: 4:00:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Bestlife Healthcare Services L
Osseo
County/Group: Hennepin County

Inspection Info

Report Number: F8087261081
Inspection Type: Full
Date: 4/14/2026
Time: 4:00:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 172 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39855016	**Date:** 4/14/2026
Facility Name: Bestlife Healthcare Services LLC	
Facility Address: 109 9th Ave NE, Osseo, MN 55369	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; 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. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

   Comments:

   Keypad locks were installed on the front door and garage door which required a code to be entered to leave the facility. These locks are not approved and require special knowledge to exit the building and do not allow ready egress during an emergency. No other primary means of egress were provided, and these locks presented a potential danger as they prevented building occupants from exiting. The locks were removed by facility staff during the survey. Egress doors should be maintained free of locks that require special knowledge, tools or effort.

   Hasp lock hardware was present in differing states of repair and operability on the exterior of several rooms in the basement including the laundry room and resident rooms. Hasp type locks are not approved on the resident room doors and should be removed as they are not openable from the egress side of the door. Hasp hardware should be removed and the doors should be equipped with only approved locking hardware.

3. Where smoking is permitted, suitable noncombustible ashtrays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

   Comments: Cigarette butts were observed scattered on the ground in the rear yard. These butts were not properly disposed of and pose risk of fire hazard. Cigarettes and other smoking materials should be properly disposed of in approved receptacles. No other appropriate receptacles were present. The

cigarette butts should be picked up from the yard and the area maintained free of improperly discarded smoking materials.

4. 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 ventilation plumbing on the back of the clothes dryer had come loose and a significant amount of lint had accumulated behind the dryer. The lint should be removed from behind the dryer. The ventilation should be properly secured and the area maintained in proper condition to prevent lint buildup.

5. 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 to power a reclining chair. Extension cords should not be used in lieu of permanent wiring.

6. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: Several smoke alarms provided in the basement were older models which exceeded ten years from their date of manufacture and were expired. These smoke alarms should be removed or replaced.

☒ **TAG IDENTIFICATION: 0780**

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

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1. Smoke alarms shall be 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: Smoke alarms were not properly interconnected such that the activation of any alarm would cause all other alarms to sound. Several partial systems were present throughout the facility, but the alarms were not all interconnected together. Hardwired alarms were present that did not properly interconnect with wireless smoke alarms throughout the facility. Hardwired smoke alarms must be maintained with their power source and must interconnect with all smoke alarms installed within the facility. Smoke alarms should be interconnected and maintained in proper working order.

☒ **TAG IDENTIFICATION: 0800**

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

   There was a nail in the railing to the lower level that was sticking out and could poke or cut someone using the railing. The nail was removed by facility staff during the survey.

   Several outlet covers were missing in the basement around electrical outlets. The outlet cover on the electrical outlet in resident room 1 was damaged and had a portion missing. Outlet covers should be replaced and maintained in proper condition to guard against contact with electrical components.

   The front screen door was not maintained in proper condition and did not latch properly.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The licensee failed to provide any facility maps in the FSEP. Floor plans were posted on the walls but would not be readily accessible in an emergency. The floor plans designated the garage as a primary exit which is not an approved primary exit route. The floor plans should be properly maintained and included in the FSEP.

2. *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 licensee failed to provide any site specific employee actions or plans for evacuation. The staff actions provided in the FSEP documents were general fire safety procedures written by a third party and were not relevant to this specific facility.

3. *Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]*

   Comments: The licensee failed to provide documentation of fire protection procedures for residents. Fire protection procedures for residents should be created and maintained.

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: The license failed to provide documentation of unique resident needs for evacuation. Specific needs for resident evacuation should be documented and maintained as updated.

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

   Comments: The licensee failed to provide documentation of employee training on the FSEP. The licensee indicated that staff was trained at hire, but that no further trainings were conducted and that no documentation was created. Staff should be trained on the FSEP upon hire and at least twice per year thereafter and documentation of the trainings should be maintained.

6. *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 licensee failed to provide documentation of resident training on the FSEP and indicated that residents are not offered training on the FSEP. Residents should be offered training on the FSEP at least once a year and that training should be documented.

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

   Comments: The licensee supplied documentation of drills which indicated that only one drill was conducted in 2025, and two drills were conducted in 2026. Drills should occur at least twice per shift per year and at least once every other month.