Electronically Delivered

March 12, 2026

Licensee
All Hopes Incorporated
7400 74th Avenue North
Brooklyn Park, MN  55428

RE: Project Number(s) SL34287016

Dear Licensee:

On March 4, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 16, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records.  It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

Electronically Delivered

February 10, 2026

Licensee
All Hopes Incorporated
7400 74th Avenue North
Brooklyn Park, MN  55428

RE:  Project Number(s) SL34287016

Dear Licensee:

On January 23, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 16, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 16, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 16, 2025, found not corrected at the time of the January 23, 2026, follow-up survey and/or subject to penalty assessment are as follows:

**0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)**
**0830-Local Laws Apply-144g.45 Subd. 3 - $500.00**

The details of the violations noted at the time of this follow-up survey completed on January 23, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

**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.

**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.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982 .

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34287 | A. BUILDING: _____ B. WING _____ | R 01/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALL HOPES INCORPORATED | 7400 74TH AVENUE N BROOKLYN PARK, MN 55428 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {0 000} | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS<br><br>INITIAL COMMENTS<br>SL34287016-1<br><br>On January 23, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 13, 2025. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued. | {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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| {0 480} | Continued From page 1<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are | {0 480} | | |

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|---|---|---|---|---|
| {0 480} | Continued From page 2<br>allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by: | {0 480} | Not reviewed during this survey. | |
| {0 510} SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by: | {0 510} | Not reviewed during this survey. | |

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|---|---|---|---|---|
| {0 800} | Continued From page 3 | {0 800} | | |
| {0 800} SS=B | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>On January 23, 2026, the surveyor initiated a follow-up for the initial survey conducted on October 13, 2025. Surveyor entered the facility at 2:36 p.m. and was met by unlicensed personnel/program coordinator (ULP/PC)-B. | {0 800} | | |

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|---|---|---|---|---|
| {0 800} | Continued From page 4<br><br>During a facility tour on January 23, 2026, from 2:41 p.m. through 3:12 p.m. with ULP/PC-B the surveyor observed that the closet door in resident room two was chipped and splintered and the entry door to resident room four was frayed at the bottom.<br><br>ULP/PC-B stated that the doors had not been repaired or replaced and that no corrections of these doors had been made since the initial survey.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | {0 800} | | |
| {0 810} SS=D | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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 5<br>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.<br>(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.<br><br>This MN Requirement is not met as evidenced by: | {0 810} | Not reviewed during this survey. | |
| {0 830} SS=F | 144G.45 Subd. 3 Local laws apply<br><br>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking.<br><br>This practice resulted in a level two violation (a | {0 830} | | |

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| {0 830} | Continued From page 6<br><br>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).<br><br>The findings include:<br><br>On January 23, 2026, the surveyor initiated a follow-up for the initial survey conducted on October 13, 2025. Surveyor entered the facility at 2:36 p.m. and was met by unlicensed personnel/program coordinator (ULP/PC)-B.<br><br>During a facility tour on January 23, 2026, from 2:41 p.m. through 3:12 p.m. ULP/PC-B and the surveyor went to the lower level of the facility. ULP/PC-B knocked on the door of resident room three. The resident allowed ULP/PC-B to open the door but did not want the surveyor to enter the room. The surveyor smelled a strong odor of cigarette smoke when ULP/PC-B opened the door. The surveyor observed the resident sitting on the bed and there appeared to be a cigarette lit on the table next to the bed. There were a few cigarette butts on the table.<br><br>During interview on January 23, 2026, at 3:16 p.m. ULP/PC-B stated that all of the residents in the facility smoke. ULP/PC-B stated that the resident in room three is the only resident that will smoke in the facility. ULP/PC-B stated the resident usually will go outside to smoke and thinks they are smoking inside today because it is so cold outside.<br><br>TIME PERIOD FOR CORRECTION: Two (2) | {0 830} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| {0 830} | Continued From page 7<br>days. | {0 830} | | |
| {01290} SS=D | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by: | {01290} | Not reviewed during this survey. | |
| {02320} SS=F | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by: | {02320} | | |

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|---|---|---|---|---|
| {02320} | Continued From page 8 | {02320} | Not reviewed during this survey. | |

Electronically Delivered

November 4, 2025

Licensee
All Hopes Incorporated
2509 Pearson Parkway
Brooklyn Park, MN  55444

RE:  Project Number(s) SL34287016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 16, 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.

**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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**
**St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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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
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CLN

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34287 | A. BUILDING: _____ B. WING _____ | 10/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ALL HOPES INCORPORATED | 2509 PEARSON PARKWAY BROOKLYN PARK, MN 55444 |

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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL34287016-0<br><br>On October 13, 2025, through October 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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;<br>(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<br><br>existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 13, 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<br>hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice had the potential to affect the licensee's residents, staff, and visitors.<br><br>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 | 0 510 | | |

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| 0 510 | Continued From page 4<br>a large portion or all of the residents).<br><br>The findings include:<br><br>On October 14, 2025, at 7:42 a.m., the surveyor observed the main level of the two-story assisted living consisted of a common area and a combined kitchen/dining area. The surveyor observed unlicensed personnel (ULP)-A administer medications to R2 while wearing gloves. With the same pair of gloves on ULP-A placed the medication cup into the trash can, then ULP-A went to the sink in the kitchen and started to wash cups and plates. With the same pair of gloves on, ULP-A placed the cups and plates into a cupboard located in the kitchen. ULP-A removed the gloves and without performing hand hygiene, walked into the common area and sat down.<br><br>On October 14, at 8:12 a.m., ULP-A stated plates and cups were used by all the residents. ULP-A stated they were trained to wash their hands immediately after taking off gloves. ULP-A stated they could not remember if they changed their gloves and performed hand hygiene after the medication administration to R2.<br><br>On October 14, 2025, at 8:52 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to wash hands immediately after glove removal. CNS-C stated the plates and cups were used by all residents. CNS-C stated the gloves were considered contaminated, and ULP-A should not have been touching the plates and cups.<br><br>The licensees Infection Control policy dated August 1, 2001, indicated licensee would follow all precautions as recommended by the Center | 0 510 | | |

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| 0 510 | Continued From page 5<br>for Disease and Control (CDC).<br><br>The CDC's Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended performing hand hygiene after glove removal.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511.<br><br>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).<br><br>The findings include:<br><br>On October 14, 2025, at 10:30 a.m., the surveyor toured the facility with unlicensed | 0 775 | | |

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| 0 775 | Continued From page 6<br><br>personnel/program coordinator (ULP/PC)-B. During the facility tour, the surveyor observed the following:<br>- A deadbolt lock requiring a key to unlock was installed on the front door. This door was designated as the primary emergency exit for the building. The use of key operated locks would delay exiting in the event of an emergency.<br>- The egress window in resident room 3 was obstructed by an exterior screen attached with screws that required tools to remove. When screens are installed on egress windows, the screens must be easily releasable from the inside without the use of tools and shall not interfere with the escape opening.<br>- At the front of the building, one burnt cigarette was disposed of on an exterior windowsill and two burnt cigarettes were on the ground. Improper disposal of smoking materials creates a fire hazard.<br>- The weatherproof cover was missing from the exterior electrial outlet installed near the front door. Weatherproof covers for electrical outlets are required in outdoor locations to prevent water damage and electrical shocks.<br>- Two extension cords were used in the basement office to supply power. Electrical extension cords shall not be used as a permanent power supply.<br><br>During the facility tour interview, ULP/PC-B verified the above listed observations.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 775 | | |
| 0 800 SS=E | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment | 0 800 | | |

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| 0 800 | Continued From page 7<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents.<br><br>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).<br><br>The findings include:<br><br>On October 14, 2025, at 10:30 a.m., the surveyor toured the facility with unlicensed personnel/program coordinator (ULP/PC)-B. During the facility tour, the surveyor observed the following:<br>- The nosing was loose on the bottom step for the main floor level stairs. | 0 800 | | |

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| 0 800 | Continued From page 8<br><br>- The vent cover was loose at the base of the main floor level stairs.<br>- In resident room 2, the exterior surface of the closet door was chipped and splintered.<br>- In resident room 4, the exterior surface of the door was frayed at the bottom.<br>- At the top of the main floor level stairs, base trim was missing at the floor/wall junction and one side of the closet door was off the track.<br><br>During the facility tour interview, ULP/PC-B verified the above listed observations.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=D | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in | 0 810 | | |

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| 0 810 | Continued From page 9<br><br>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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to provide the required drill frequency.<br><br>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).<br><br>The findings include:<br><br>On October 14, 2025, unlicensed personnel/program coordinator (ULP/PC)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. | 0 810 | | |

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| 0 810 | Continued From page 10<br><br>DRILLS<br>Record review indicated the licensee failed to conduct evacuation drills for employees at a frequency of every other month evident by fire drill documentation lacking the required frequency. Evacuation drill logs from October 2024 to August 2025 were provided. Twelve fire drills were recorded, evacuation fire drills were not completed in April, May, June, or July 2025.<br><br>During an interview on October 14, 2025, at 11:35 a.m., ULP/PC-B verified the evacuation fire drill frequency was not met.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 830 SS=F | 144G.45 Subd. 3 Local laws apply<br><br>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for two of three residents (R1, R2). | 0 830 | | |

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| 0 830 | Continued From page 11<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted to the facility on June 20, 2022, and began receiving direct care services.<br><br>R1's diagnoses included schizophrenia (a chronic mental health condition that affects a person's thoughts, emotions and behaviors), schizoaffective disorder (a chronic mental health condition that combines a mood disorder), and bipolar disorder (a chronic mental health condition characterized by extreme mood swings between mania (state of fast thoughts) and depression (state of feeling low).<br><br>R1's signed Service Plan (Wavier) - Addendum to Contract dated November 6, 2024, indicated R1 received assistance with appointment reminders, bathing reminder, bedmaking, deep room cleaning, drinking assistance, grooming, laundry, linen change, behaver management, meal assistance, medication management, vital signs, garbage removal, and safety checks.<br><br>R2<br>R2 was admitted to the facility on August 11, 2022, and began receiving direct care services. | 0 830 | | |

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| 0 830 | Continued From page 12<br><br>R2's diagnoses included unspecified schizophrenia, alcohol use disorder, antisocial personality traits (a mental health condition characterized by a pervasive pattern of disregard for and violation of rights of others), and cannabis use disorder.<br><br>R2's signed Service Plan (Waiver) - Addendum to Contract dated June 23, 2025, indicated R2 received assistance with medication management, vital signs, garbage removal, safety checks, socialization, activity assistance, appointment reminders, bathing reminder, bedmaking, deep room cleaning, grooming, laundry, linen change, behavior management and, meals.<br><br>On October 13, 2025, at 9:35 a.m., the surveyor entered the two-story assisted living facility (ALF). There was a strong smell of cigarette smoke.<br><br>On October 13, 2025, at 10:48 a.m., on the lower level of the ALF, the surveyor entered R1's room and observed 2 cigarette ends on the floor. There was a side table next to the bed which was covered in a white ash material. The room had a smell of cigarette smoke.<br><br>On October 13, 2025, at 11:56 a.m., registered nurse/licensed assisted living director (RN/LALD)-D and the surveyor entered R2's room and observed a circular side table. On the table was a bundle of green stems and what appeared to be paper tied with twine. On one of the ends there were signs the bundle had been burned, appearing black and charred. On the table there was a flat rectangular rock that had | 0 830 | | |

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|---|---|---|---|
| | 34287 | A. BUILDING: _____ B. WING _____ | 10/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALL HOPES INCORPORATED | 2509 PEARSON PARKWAY BROOKLYN PARK, MN 55444 |

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|---|---|---|---|---|
| 0 830 | Continued From page 13<br><br>burnt material on it. There were two small black marks in a circular pattern that appeared to be burn marks and, on the table, there was white ash.<br><br>On October 13, 2025, at 12:02 p.m., R2 stated the bundle contained sage. R2 stated they would light the bundle and wave it around their person and would place the bundle onto the rock. R2 stated this was a cultural practice and the last time they performed that was about four months ago.<br><br>On October 13, 2025, at 12:03 p.m., unlicensed personnel (ULP)-A stated they had not smelled the cigarette smoke in the facility and had never seen R1 smoke inside the facility. ULP-A stated they had not observed R2 burning the sage inside the facility.<br><br>On October 13, 2025, at 12:06 p.m., case manager (CM)-H stated they were unaware that R1 was smoking in the ALF.<br><br>R1's record lacked documentation of observed smoking, documented care plan related to the smoking, and interventions for staff to follow if R1 was observed smoking inside the ALF.<br><br>On October 15, 2025, at 12:29 p.m., RN/LALD-D stated the ALF was a smoke free facility and residents were encouraged to smoke outside. RN/LALD-D stated staff were trained to redirect residents to smoke outside. RN/LALD-D stated the interventions for stopping the smoking was to place a smoke detector in R1's room. RN/LALD-D stated the smoke detector would not stop the smoking but would alert staff if there was smoking occurring. RN/LALD-D stated they did | 0 830 | | |

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|---|---|---|---|---|
| 0 830 | Continued From page 14<br><br>not have a plan for next steps. RN/LALD-D stated they were unaware R2 was burning sage in their room.<br><br>On October 15, 2025, at 1:29 p.m., clinical nurse supervisor (CNS)-C stated R1's record lacked documented interventions related to the smoking. CNS-C was not made aware of interventions that had been put in place.<br><br>On October 15, 2025, at 1:35 p.m. RN/LALD-D stated it was an oversight for not including those interventions into R1's file. RN/LALD-D stated they believed the safety check that was performed every two hours was enough of an intervention to prevent the smoking.<br><br>The licensee's undated Smoking policy indicated the ALF was a non-smoking facility.<br><br>The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. MCIAA defined smoking to include: carrying or using an activated electronic delivery device.<br><br>Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed | 0 830 | | |

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| 0 830 | Continued From page 15<br><br>residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 830 | | |
| 01290 SS=D | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living licensee's current health | 01290 | | |

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| 01290 | Continued From page 16<br><br>facility identification (HFID) for one of nine employees (unlicensed personnel (ULP)-E).<br><br>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).<br><br>The findings include:<br><br>The licensee's HFID was 34287.<br><br>ULP-E was hired on March 6, 2021, to provide direct care services.<br><br>The licensee's staff schedule dated September 21, 2025, through October 18, 2025, indicated ULP-E was scheduled to work four shifts.<br><br>The licensee's NETStudy 2.0 (web-based system used for submitting background study requests to the Department of Human Services) roster for HFID 34287 showed an expired COVID eligible cleared background check for ULP-E. ULP-E also had a cleared background study on a roster afflicted with HFID 35715, which was not an expired background check.<br><br>ULP-E did not have a cleared background check affiliated to HFID 34287.<br><br>The licensee's Department of Health License and Registration Application for HFID 34287 and HFID 35715 indicated registered nurse/licensed | 01290 | | |

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| 01290 | Continued From page 17<br><br>assisted living director (RN/LALD)-D was the owner of each facility at 100 percent (%).<br><br>On October 14, 2025, at 12:54 p.m., RN/LALD-D stated when a person was hired to work for the licensee, they would conduct a NETStudy 2.0 background check before they were allowed to perform direct care services. RN/LALD-D stated they owned a sister facility HFID 35715. RN/LALD-D stated ULP-E was originally hired to work at the facility HFID 35715. RN/LALD-D stated they were aware employees providing direct services were required to have a background check affiliated to the facility where they were providing cares. RN/LALD-D stated that was a miss for not having ULP-E affiliated to the HFID 34287.<br><br>The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated staff providing direct care services would have a NETStudy 2.0 background check affiliated to the facility they were performing work in.<br><br>The Minnesota Department of Human Services website indicated the following:<br>Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study.<br>Roster maintenance<br>- Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated;<br>- If the individual should no longer be affiliated and has a new fully compliant background study, | 01290 | | |

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| 01290 | Continued From page 18<br><br>the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time;<br>- All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and<br>- Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 01290 | | |
| 02320 SS=F | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-A) followed appropriate medication administration procedures. | 02320 | | |

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| 02320 | Continued From page 19<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted on June 20, 2022, and began receiving assisted living services.<br><br>R1's signed Service Plan (Wavier) - Addendum to Contract dated November 6, 2024, indicated R1 received assistance with medication administration.<br><br>R2<br>R2 was admitted to the facility on August 11, 2022, and began receiving assisted living services.<br><br>R2's signed Service Plan (Waiver) - Addendum to Contract dated June 23, 2025, indicated R2 received assistance with medication administration.<br><br>R3<br>R3 was admitted to the facility on March 12, 2024, and began receiving assisted living services.<br><br>R3's signed Service Plan (Waiver) - Addendum to Contract dated June 9, 2025, indicated R3 | 02320 | | |

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| 02320 | Continued From page 20<br><br>received assistance with medication administration.<br><br>UNSECURED MEDICATIONS.<br>On October 14, 2025, at 7:05 a.m., the surveyor observed the main level of this assisted living facility (ALF) consisted of a common area, kitchen/dining area, a hallway leading to resident rooms, and a bathroom. The surveyor observed ULP-A walk to the kitchen table and place a plate of breakfast with a medication cup that contained two pills. R1 walked to the kitchen table and sat down. ULP-A walked away from the table toward the hallway. With no staff able to observe the medications, R1 ingested the medications, finished the breakfast and left the facility.<br><br>On October 14, 2025, at 7:10 a.m., ULP-A returned to the kitchen table, picked up the medication cup and breakfast plate, placed the medication cup in the trash can, and placed the plate into the kitchen sink.<br><br>On October 14, 2025, at 8:06 a.m., ULP-A stated they were trained to observe residents take the medications. ULP-A stated they may have gone to the bathroom after placing the medications onto the kitchen table. ULP-A stated they were sure they supervised R1 take the medications. The surveyor stated to ULP-A there were no staff in the area at the time R1 ingested the medications and asked how they observed R1 ingest the medications. ULP-A did not respond to the question.<br><br>On October 14, 2025, at 8:52 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to observe residents ingest their medications. CNS-C stated that practice was a safety issue as | 02320 | | |

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| 02320 | Continued From page 21<br><br>anyone could have taken the medications and the situation should not have occurred.<br><br>UNSECURED MEDICATION CABINET<br>On October 14, 2025, at 7:28 a.m., the surveyor observed a medication cabinet on the main level of the ALF in the dining area. The surveyor observed ULP-A unlock the medication cabinet, place medications into a medication cup for R3 and close the cabinet door. Without locking the cabinet, and with no other staff present, ULP-A walked away from the medication cabinet, through the kitchen, down the hallway, and entered R3's bedroom and administered the medications.<br><br>On October 14, 2025, at 7:32 a.m., ULP-A walked back into the kitchen. ULP-A stated they were trained to keep the medication cabinet locked and believed the medication cabinet was locked.<br><br>On October 14, 2025, at 8:52 a.m., CNS-C stated staff were trained to keep the medication cabinet locked. CNS-C stated leaving the medication cabinet unlocked could result in any person accessing the medications. CNS-C stated they were unsure why it was not locked.<br><br>The licensee's Storage/Controlled Medications policy dated August 1, 2021, indicated licensee would securely lock all medications and would only allow authorized personnel to have access to the stored medications.<br><br>DID NOT VERIFY MEDICATIONS BEFORE ADMINISTRATION.<br>On October 14, 2025, at 7:28 a.m., the surveyor observed ULP-A place three medications from a | 02320 | | |

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| 02320 | Continued From page 22<br><br>bubble pack for R3 into a medication cup from a medication cabinet located in the kitchen/dining area. Without verifying the medications against an electronic medical record (EMAR), ULP-A administered the medications to R3.<br><br>On October 14, 2025, at 7:42 a.m., the surveyor observed ULP-A take a bubble pack of medications for R2 from the medication cabinet. ULP-A placed two medications into a medication cup, and without verifying the medications against an EMAR, ULP-A administered the medications to R2.<br><br>On October 14, 2025, at 7:34 a.m., and 8:01 a.m., ULP-A stated they were trained to verify the medications against an EMAR before administering the medications to residents. ULP-A stated the internet was not working at the facility, therefore they could not verify the medications against the EMAR. ULP-A stated they would write down the medication administration on a piece of paper and would give that to CNS-C. ULP-A stated they never received training about what to do when the internet was not working.<br><br>On October 14, 2025, at 9:02 a.m., CNS-C stated staff were trained to verify the medications against the EMAR prior to administrating medications. CNS-C stated staff were trained to contact leadership if there was no internet available and were not able to access the EMAR. CNS-C stated they were not aware the internet was not working. CNS-C stated there was a safety risk if the EMAR was not followed for medication administration and the situation should not have occurred. | 02320 | | |

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| 02320 | Continued From page 23<br><br>On October 14, 2025, at 9:19 a.m., registered nurse/licensed assisted living director (RN/LALD)-D stated staff were trained to call the clinical nurse supervisor or the license assisted living director before administering medications if they could not access the EMAR. RN/LALD-D stated staff should have waited for a paper copy of the medication administration record (MAR). RN/LALD-D stated it was a safety concern for the resident if staff do not follow the EMAR or MAR for medication administration.<br><br>On October 15, 2025, at 12:57 p.m., RN/LALD-D stated the licensee's emergency preparedness plan lacked guidance for staff when there was no internet available for the facility.<br><br>The licensees Medication Administration policy dated August 1, 2021, indicated staff would have access to information about medications being administered including purpose, dose, route, frequency, instructions related to the medication and specific to the residents as appropriate, side effects and resin allergies to medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02320 | | |

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

# Food & Beverage Inspection Report



## Establishment Info

ALL HOPES INCORPORATED
2509 PEARSON PARKWAY
Brooklyn Park, MN 55444
Hennepin County
Parcel:

Phone:

## License Info

License: HFID 34287

Risk:
License:
Expires on:
CFPM: JT A. Awosika
CFPM #: FM123448; Exp: 05/15/2027

## Inspection Info

Report Number: F1005251163
Inspection Type: Full - Single
Date: 10/13/2025 Time: 11:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

**New Order: 3-500C Microbial Control: date marking**
3-501.17B *Priority Level: Priority 2 CFP#: 23*
*MN Rule 4626.0400B* Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPENED CONTAINERS OF TCS FOODS WERE NOT DATE MARKED, INCLUDING MILK, DELI MEAT, AND TUNA SALAD. REVIEWED THE REQUIREMENTS TO MARK FOODS WITH THE DATE THEY ARE OPENED TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS OF OPENING.
*Comply By: 10/13/2025 Originally Issued On: 10/13/2025*

# Food & Beverage General Comment

INSPECTION COMPLETED WITH STAFF AND REVIEWED WITH HRD NURSING EVALUATOR, KEITH LANGLEY.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

THERMOLABELS FOR THE DISHWASHER WERE ON SITE. STAFF SENT INSPECTOR A PICTURE OF A LABEL THAT THEY RAN THROUGH THE DISHWASHER, AND IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 170+ DEGREES F.

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL 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.

**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 F1005251163 from 10/13/2025**

VICTOR AWOSIKA

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@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

ALL HOPES INCORPORATED
Brooklyn Park
County/Group: Hennepin County

## Inspection Info

Report Number: F1005251163
Inspection Type: Full
Date: 10/13/2025
Time: 11:30 AM

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

**Food Temperature: Product/Item/Unit:** TUNA SALAD**; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 38 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

ALL HOPES INCORPORATED
Brooklyn Park
County/Group: Hennepin County

## Inspection Info

Report Number: F1005251163
Inspection Type: Full
Date: 10/13/2025
Time: 11:30 AM

**Sanitizing Equipment:** **Product:** Hot Water**; Sanitizing Process:** DISHWASHER
**Location:** **Equal To** 170 Degrees F.
Comment: AT LEAST 170dF AS INDICATED BY THERMOLABEL
*Violation Issued?: No*