Electronically Delivered

August 12, 2026

Licensee
Hopeville Homes
4925 78th Lane North
Brooklyn Park, MN  55443

RE:  Project Number(s) SL36709016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 8, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

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

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

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

**St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - 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 $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.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

KKM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36709 | A. BUILDING: _____ B. WING _____ | 07/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HOPEVILLE HOMES | 4925 78TH LANE NORTH BROOKLYN PARK, MN 55443 |

| (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 |
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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>SL36709016-0<br><br>On July 6, 2026 through July, 8, 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 resident(s); four receiving services under the Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<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>(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><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:<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 the potential to affect a large portion or all of the residents).<br><br>The findings include:<br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 7, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer | 0 480 | | |

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| 0 480 | Continued From page 3<br>to the FBEIR for any compliance dates. | 0 480 | | |
| 0 650 SS=E | 144G.42 Subd. 8 (a) Staff records<br><br>(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:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(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<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented competency evaluations for two of two unlicensed personnel ((ULP)-A, ULP-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 650 | | |

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| 0 650 | Continued From page 4<br><br>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>ULP-A<br>ULP-A was hired on November 1, 2021, to provide direct care to the residents.<br><br>On July 7, 2026, at 8:57 a.m., the surveyor observed ULP-A assist R1 with medication administration. ULP-A checked R1's blood sugar using their freestyle Libre. ULP-A stated once in a while they would need to poke R1's finger to check the blood sugar.<br><br>ULP-B<br>ULP-B was hired on October 14, 2021, to provide direct care to the residents.<br><br>ULP-A and ULP-B's records lacked documentation of competency evaluations related to blood glucose.<br><br>On July 7, 2026, at 9:16 a.m., ULP-A stated clinical nurse supervisor (CNS)-D had trained them on blood glucose procedure and had showed them how to perform a blood glucose check. ULP-A stated they could not recall if they had to return demonstration at that time but confirmed CNS-D had observed them performing the task.<br><br>On July 7, 2026, at 9:53 a.m., CNS-D stated they | 0 650 | | |

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| 0 650 | Continued From page 5<br><br>had personally trained all staff at this location on blood sugars years ago. CNS-D stated the documentation of the competency evaluations should have been in the personnel record.<br><br>On July 7, 2026, at 10:03 a.m., licensed assisted living director (LALD)-C confirmed the licensee could not locate the documentation for blood glucose evaluations for ULP-A and ULP-B. LALD-C stated they were not sure how the documentation had gotten missed placed and not filed in the personnel records.<br><br>On July 7, 2026, at 11:37 a.m., the surveyor observed CNS-D reviewing personnel records. CNS-D stated every other staff had their blood glucose competency evaluations in the personnel record except for the two oldest employees that had been with the licensee the longest. CNS-D confirmed that the documentation of the competency evaluations for blood glucose was not in the record for ULP-A and ULP-B.<br><br>The licensee's Personnel Records policy dated February 20, 2026, indicated all documents of competency evaluations would be kept in personnel records.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current | 0 660 | | |

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| 0 660 | Continued From page 6<br><br>tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include TB training annually for two of two unlicensed personnel ((ULP)-A, ULP-B). This had the potential to affect all 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 the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee's Facility TB Risk Assessment dated January 5, 2026, indicated the facility was at a | 0 660 | | |

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| 0 660 | Continued From page 7<br>low risk for TB transmission.<br><br>ULP-A<br>ULP-A was hired on November 1, 2021, to provide direct care to the residents.<br><br>On July 7, 2026, at 8:57 a.m., the surveyor observed ULP-A assist R1 with medication administration.<br><br>ULP-A's transcript dated May 27, 2026, indicated ULP-A had OSHA and Infection Control (w/TB) training completed on October 30, 2021. ULP-A's personnel record lacked annual TB training in 2022, 2023, 2024, and 2025.<br><br>ULP-B<br>ULP-B was hired on October 14, 2021, to provide direct care to the residents.<br><br>ULP-B's transcript dated May 27, 2026, indicated ULP-B had OSHA and Infection Control (w/TB) training completed on October 4, 2021. ULP-B's personnel record lacked annual TB training in 2022, 2023, 2024, and 2025.<br><br>On July 7, 2026, at 8:15 a.m., licensed assisted living director (LALD)-C stated the licensee completed TB testing at hire and annual TB evaluations but the licensee did not provide TB specific training annually.<br><br>The licensee's Tuberculosis Screening/Prevention policy dated January 11, 2026, indicated all staff who provided care or visited residents (including volunteers) would receive education regarding TB; and on-going TB training annually as part of the infection control training. The policy indicated the TB training included the following: | 0 660 | | |

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| 0 660 | Continued From page 8<br><br>- general training on TB;<br>- the importance of evaluation of symptoms or signs of TB disease for early detection and treatment of TB disease;<br>- the role of the caregiver in educating residents regarding the importance of reporting symptoms or signs of TB disease; and<br>- the importance of reporting any adverse effects to treatment for LTBI or TB disease.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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 | 0 680 | | |

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| 0 680 | Continued From page 9<br><br>allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>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.<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>The licensee's undated EPP lacked evidence of the following required content:<br>- maintain and update annually;<br>- subsistence needs for staff and residents;<br>- procedures for tracking of staff and patients;<br>- policies and procedures for medical documents;<br>- policies and procedures for volunteers;<br>- arrangement with other facilities;<br>- roles under a wavier declared by secretary;<br>- names and contact information;<br>- emergency officials contact information;<br>- primary/alternate means for communication;<br>- methods for sharing information; and<br>- sharing information on occupancy/needs. | 0 680 | | |

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| 0 680 | Continued From page 10<br><br>On July 7, 2026, at 12:31 p.m., licensed assisted living director (LALD)-C confirmed the facility's risk assessment was blank. LALD-C stated they thought the example shown in the licensee's EPP were hazards that applied to their facility. After the surveyor explained the facility hazard assessment needed to be an all-hazard approach, LALD-C stated the licensee did not have a facility hazard assessment with an all-hazards approach. LALD-C stated the licensee's EPP did not address policies and procedures for food, water, medical and pharmacy, waste disposal. LALD-C confirmed the licensee did not have a system for tracking staff and residents in the EPP. LALD-C stated the licensee did not have a written arrangement with other facilities as they would utilize one of the other facilities owned by the licensee.<br><br>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place an emergency preparedness plan to assure the safety and well-being of residents and staff during periods of an emergency or disaster that would disrupt services. The policy referenced CMS (Centers for Medicare and Medicaid Services) State Operations Manual Appendix Z.<br><br>Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." | 0 680 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 0 680 | Continued From page 11<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 730 SS=F | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the | 0 730 | | |

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| 0 730 | Continued From page 12<br><br>needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to document resident assessments that included required content of an individualized abuse prevention plan for two of two residents (R1 and R2); and failed to document a medication assessment for one of one resident (R1).<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>Individualized Abuse Prevention Plan<br>R1 | 0 730 | | |

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| 0 730 | Continued From page 13<br><br>R1 was admitted to licensee on January 1, 2026, with diagnoses of post-traumatic stress disorder, anxiety, depression, diabetes, and insomnia.<br><br>R1's Service Plan (Private) - Addendum to Contract dated January 1, 2026, indicated R1 received assistance with medication administration.<br><br>R1's Individual Abuse Prevention Plan - As of Date (IAPP) dated June 21, 2026, indicated R1 relied on staff assistance with bathing, eating, hygiene, grooming, oral care, medication administration, housekeeping, laundry, shopping, and transportation. R1's IAPP lacked an assessment of R1's susceptibility of abuse and interventions to prevent potential abuse. R1's IAPP indicated R1 was at risk of abusing other vulnerable adults due to a history of verbal and physical aggression.<br><br>R2<br>R2 was admitted to licensee on July 15, 2021, with diagnoses of cerebral palsy, anxiety, depression, epilepsy, and moderate intellectual disorder.<br><br>R2's Service Plan (Private) - Addendum to Contract dated May 22, 2026, indicated R2 received assistance with medication administration.<br><br>R2's IAPP dated May 22, 2026, indicated R2 relied on staff assistance with bathing, dressing, eating, hygiene, grooming, oral care, ambulation, bed mobility, transfers, hydration, oxygen equipment, toileting needs, medication administration, housekeeping, shopping, and transportation. Also, R2's IAPP indicated R2 had difficulty with communication and may not report | 0 730 | | |

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| 0 730 | Continued From page 14<br><br>abuse or neglect. R2's IAPP lacked an assessment of R2's susceptibility of abuse and interventions to prevent potential abuse. R2's IAPP indicated R2 had no known risk to abuse other vulnerable adults.<br><br>On July 8, 2026, at 12:13 p.m., clinical nurse supervisor (CNS)-D stated they used to document the resident's susceptibility of abuse in all IAPP's. CNS-D stated they had assessed the resident's susceptibility of abuse but did not document it in the IAPPs.<br><br>On July 8, 2026, at 3:03 p.m., CNS-D stated they used to document the residents' susceptibility to abuse but had been informed in the past by a representative from Minnesota Department of Health (MDH) that they should not document everyone is susceptible to abuse for every resident. CNS-D stated they assessed all residents for susceptibility to abuse but did not think they were at risk of being abused so they did not document the assessment to determine if the resident was at risk.<br><br>The licensee's Abuse Prevention Plan policy dated January 20, 2026, indicated all residents admitted would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults. The policy indicated the IAPP would reflect the client's ability to participate in and direct their own care or the presence of an identified caregiver. Also, the policy indicated that the comprehensive assessment would be documented in the clinical record.<br><br>Medication Assessment<br>R1 was admitted to licensee on January 1, 2026, with diagnoses of post-traumatic stress disorder, | 0 730 | | |

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| 0 730 | Continued From page 15<br>anxiety, depression, diabetes, and insomnia.<br><br>R1's Service Plan (Private) - Addendum to Contract dated January 1, 2026, indicated R1 received assistance with medication administration and blood glucose monitoring three times per day.<br><br>R1's assessment dated May 22, 2026, under section Medications, indicated staff would assist with all medication for medication administration; self-administration of medications was not applicable but R1 could administer ointment as requested independently. Also, under section Physical, indicated R1 was diabetic with a note of insulin and metformin. The assessment lacked indication of R1's list of treatments for blood glucose monitoring and management of diabetes equipment, including type, frequency, and level of assistance needed.<br><br>On July 8, 2026, at 2:14 p.m., CNS-D stated R1 was observed and signed off as being able to self-administer their insulin, self-manage their blood sugars, and management of their diabetes equipment. CNS-D confirmed they had assessed the safety of these tasks; and the assessment should have been included in the last assessment completed as this is assessed during each comprehensive assessment. CNS-D stated if the information was not in the last assessment, then it was not in the record.<br><br>Minnesota Administrative Rule 4659.0150, subpart 2, D., (4), a - j, indicated a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, included prescriptions, over-the-counter medications, and supplements, and for each:<br>(a) the reason taken; | 0 730 | | |

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| 0 730 | Continued From page 16<br><br>(b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues;<br>(c) the dosage;<br>(d) the frequency of use;<br>(e) the route administered or taken;<br>(f) any difficulties the resident faces in taking the medication;<br>(g) whether the resident self administers the medication;<br>(h) the resident's preferences in how to take medication;<br>(i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and<br>(j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.<br><br>Minnesota Administrative Rule 4659.0150, subpart 2, K., indicated the uniform assessment must include a list of treatments, including type, frequency, and level of assistance needed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 730 | | |
| 0 810 SS=F | 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 | 0 810 | | |

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| 0 810 | Continued From page 17<br><br>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 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 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.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 810 | | |

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| 0 810 | Continued From page 18<br><br>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>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) Days | 0 810 | | |
| 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. | 01290 | | |

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| 01290 | Continued From page 19<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 (BGS) was associated with the licensee's assisted living facility's health facility identification number (HFID) for one of one registered nurse ((RN)-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>RN-E was hired by the licensee on May 20, 2024.<br><br>According to The Minnesota Board of Nursing website accessed on July 7, 2026, at 11:51 a.m., RN-E became an active RN on July 21, 2016, therefore was required to have a BGS completed by the licensee.<br><br>RN-E's Department of Human Services BGS clearance dated December 24, 2023, indicated RN-E was cleared and associated with a different HFID 39424, which was owned by the same owner as the license for HFID 36709. The BGS was not associated with the license's HFID 36709 where RN-E had access to residents.<br><br>On July 7, 2026, at 11:40 a.m., clinical nurse supervisor (CNS)-D verified RN-E was licensed as an RN in 2016 and currently did not hold a | 01290 | | |

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| 01290 | Continued From page 20<br><br>license through Minnesota Board of Executives for Long-Term Services and Supports.<br><br>On July 7, 2026, at 12:11 p.m., licensed assisted living director (LALD)-C stated it was an oversight the licensee did not affiliate RN-E to the licensee's HFID 36709.<br><br>The licensee's Background Studies policy dated February 20, 2026, indicated background screening would be completed for employment. Also, the policy indicated the BGS would be retained in the employee file. The policy referenced Statute 144A and not Statute 144G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01290 | | |
| 01500 SS=F | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal | 01500 | | |

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| 01500 | Continued From page 21<br>of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. | 01500 | | |

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| 01500 | Continued From page 22<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for two of two unlicensed personnel ((ULP)-A, ULP-B).<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>ULP-A<br>On July 7, 2026, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration.<br><br>ULP-A was hired on November 1, 2021, to provide direct care to the residents.<br><br>ULP-A's personnel record lacked evidence of the following required topics of annual training in 2025:<br>- Assisted Living Bill of Rights;<br>- infection control techniques;<br>- effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and<br>- principles of person-centered planning/service delivery. | 01500 | | |

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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 |
|---|---|---|---|---|
| 01500 | Continued From page 23<br><br>ULP-A's personnel record lacked evidence of the following required topics of annual training in 2023:<br>- Assisted Living Bill of Rights;<br>- infection control techniques; and<br>- effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders.<br><br>ULP-B<br>ULP-B was hired on October 14, 2021, to provide direct care to the residents.<br><br>ULP-B's personnel record lacked evidence of the following required topics of annual training in 2025:<br>- Assisted Living Bill of Rights;<br>- infection control techniques; and<br>- principles of person-centered planning/service delivery.<br><br>ULP-B's personnel record lacked evidence of the following required topics of annual training in 2024:<br>- Assisted Living Bill of Rights;<br>- infection control techniques;<br>- effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and<br>- principles of person-centered planning/service delivery.<br><br>ULP-B's personnel record lacked evidence the required annual training topic on Assisted Living Bill of Rights in 2023. | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36709 | A. BUILDING: _____ B. WING _____ | 07/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOPEVILLE HOMES | 4925 78TH LANE NORTH BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 01500 | Continued From page 24<br><br>On July 7, 2026, at 8:27 p.m., licensed assisted living director (LALD)-C acknowledged the missing annual training topics for both ULP-A and ULP-B. LALD-C stated they assigned the courses annually but perhaps the assigned courses were not completed by the staff. LALD-C asked the surveyor if training on the Assisted Living Bill of Rights was required annually. LALD-C stated they assigned the annual training, but the staff would complete the training at different times due to scheduling. LALD-C stated the licensee tried the best they could to ensure staff completed the assigned training, but often they would have to go back and forth with staff to ensure the completion of the required annual training.<br><br>The licensee's Unlicensed Personnel Annual Training Requirements policy dated January 11, 2026, indicated all staff that provided direct services must complete at least eight (8) hours of annual training for each 12 months of employment. The policy indicated the annual training must include topics on reporting of maltreatment of adults; and infection control techniques. The policy excluded required annual training topics for Assisted Living Bill of Right; effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. The policy referenced Statute 144A and not Statute 144G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36709 | A. BUILDING: _____ B. WING _____ | 07/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOPEVILLE HOMES | 4925 78TH LANE NORTH BROOKLYN PARK, MN 55443 |

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|---|---|---|---|---|
| 01500 | Continued From page 25<br>(21) days | 01500 | | |
| 01820 SS=F | 144G.71 Subd. 13 Prescriptions<br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were maintained for one of one resident (R1).<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 July 7, 2026, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration.<br><br>R1 was admitted to licensee on January 1, 2026.<br><br>R1's Service Plan (Private) - Addendum to Contract dated January 1, 2026, indicated R1 received assistance with medication administration. | 01820 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36709 | A. BUILDING: _____ B. WING _____ | 07/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HOPEVILLE HOMES | 4925 78TH LANE NORTH BROOKLYN PARK, MN 55443 |

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|---|---|---|---|---|
| 01820 | Continued From page 26<br><br>R1's Assessment dated May 22, 2026, indicated R1 required assistance with medication management and administration of medications.<br><br>R1's Med Admin Summary - Actual - Month dated July 2026, indicated the licensee assisted with the following medications to be administered:<br>- Novolog Flexpen inject 1 unit (u) daily before each meal; and<br>- hydroxyzine HCL 50 milligrams (mg) one tablet by mouth at bedtime.<br><br>R1's record lacked signed provider orders for the following medications:<br>- Novolog Flexpen inject 1 u daily before each meal; and<br>- hydroxyzine HCL 50 mg one tablet by mouth at bedtime.<br><br>On July 8, 2026, at 12:20 p.m., clinical nurse supervisor (CNS)-D stated the licensee used a Provider Contact form printed from the licensee's electronic record to get all orders from the residents' providers when the residents had medical appointments. CNS-D acknowledge the provider would only sign below the section that indicated Provider Comments/New Diagnosis and New Orders. CNS-D acknowledge the providers did not acknowledge the printed medication or treatment list provided with the Provider Contact form. CNS-D stated it was difficult to get signed orders from the providers; and that was why the licensee would set up annual physicals for their residents. CNS-D stated the licensee would need to change their process for getting signed orders.<br><br>On July 8, 2026, at 2:25 p.m., CNS-D stated they had provided all medication orders the licensee was able to obtain from the dispensing pharmacy | 01820 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36709 | A. BUILDING: _____ B. WING _____ | 07/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOPEVILLE HOMES | 4925 78TH LANE NORTH BROOKLYN PARK, MN 55443 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01820 | Continued From page 27<br><br>and confirmed they were not able to obtain the missing orders.<br><br>The licensee's Medication Orders policy dated January 20, 2026, indicated the licensee would verify with the physician any incomplete, illegible, or unclear medication orders prior to administered medications and/or provided education to the resident. The policy referenced Statute 144A and not Statute 144G.<br><br>The licensee's Medication Administration policy dated November 11, 2025, indicated the licensee's nurse would compare physician orders with a medication label prior to the administration of the medication. The policy referenced Statute 144A and not Statute 144G.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01820 | | |

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

# Food & Beverage Inspection Report



## Establishment Info

Hopeville Homes
4925 78TH LANE NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:
carlossmith@hopevillehomes.com

## License Info

License: HFID 36709

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

## Inspection Info

Report Number: F8044261196
Inspection Type: Full - Single
Date: 7/7/2026 Time: 10:45:22 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

**New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control**
6-501.12A *Priority Level: Priority 3 CFP#: 55*
*MN Rule 4626.1520A* Clean and maintain all physical facilities clean.
COMMENT: Mouse droppings next to mouse trap in cupboard under kitchen sink.
*Comply By: 7/7/2026 Originally Issued On: 7/7/2026*

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
*MN Rule 4626.1620* Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: Lysol wipes used on food contact surfaces are not approved.
*Comply By: 7/7/2026 Originally Issued On: 7/7/2026*

# Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Rhawnie Quinehan. Inspection report reviewed on site with Carlos.

Kitchen consists of vinyl floors, painted gypsum walls and ceilings, wooden hollow base cabinets, quartz counters, and domestic equipment.

**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 Rochester District Office inspection report number F8044261196 from 7/7/2026**

Carlos
Owner

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

# Temperature Observations/Recordings



## Establishment Info

Hopeville Homes
Brooklyn Park
County/Group: Hennepin County

## Inspection Info

Report Number: F8044261196
Inspection Type: Full
Date: 7/7/2026
Time: 10:45:22 AM

**Food Temperature: Product/Item/Unit:** Deli turkey meat**; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 38.9 Degrees F.
Comment:
*Violation Issued?: No*

**Equipment Temperature: Product/Item/Unit: ; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 39.0 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** Eggs**; Temperature Process:** Cooking
**Location:** Stove at 155.0 Degrees F.
Comment:
*Violation Issued?: No*

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

# Sanitizer Observations/Recordings



## Establishment Info

Hopeville Homes
Brooklyn Park
County/Group: Hennepin County

## Inspection Info

Report Number: F8044261196
Inspection Type: Full
Date: 7/7/2026
Time: 10:45:22 AM

**Sanitizing Equipment**: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
**Location:** Kitchen **Equal To** 163.4 Degrees F.
Comment:
*Violation Issued?: No*

DEPARTMENT OF HEALTH

# Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

| | |
|---|---|
| **Project No:** SL36709016-0 | **Date:** 7/7/2026 |
| **Facility Name:** HOPEVILLE HOMES | |
| **Facility Address:** 4925 78TH LANE NORTH BROOKLYN PARK MN 55443 | |

☒ **TAG IDENTIFICATION: 0810**

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

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

   *Comments: The room identification at each room did not match the room identification on the posted evacuation plans.*

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 FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the 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 FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The licensee stated a resident policy was not in place at the time of the survey.*

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 FSEP did not identify specific unique and unusual needs for residents. There was no section in the policy that addressed the individual evacuation requirements to assist residents during an evacuation event.*