Electronically Delivered

May 6, 2026

Licensee
Cosmo Home Healthcare Services
6425 Dawn Way
Inver Grove Heights, MN 55076

RE: Project Number(s)

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 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 - 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
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

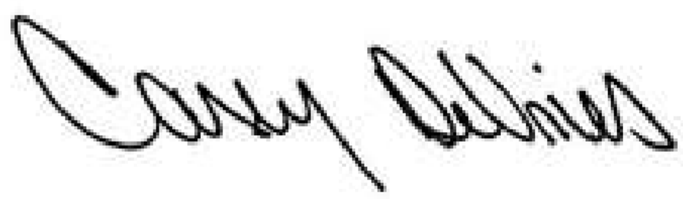
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37294	A. BUILDING: _____ B. WING _____	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COSMO HOME HEALTHCARE SERVICES	6425 DAWN WAY INVER GROVE HEIGHTS, MN 55076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37294016-0 On April 6, 2026, through April 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 was one resident; one receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 6, 2026, at 11:02 a.m., during an audit of the licensee's medication storage closet, on the floor in the back right corner the surveyor observed what appeared to be a mouse dropping intermixed with gray dust and sawdust.	0 510		

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0 510	Continued From page 2 On April 7, 2026, at 3:23 p.m., agent (A)-A stated they were not sure how long the mouse droppings were in the closet as their only client was not using the closet for medication storage and their last client that utilized the closet for medication storage had moved out of the facility some time ago. A-A stated that going forward, they would make sure staff cleaned more thoroughly to monitor for signs of infestations. The licensee's Infection Control policy dated December 16, 2016, indicated the licensee would observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). The Centers for Disease Control (CDC), Controlling Wild Rodent Infestation document dated April 8, 2024, indicated the following: "Rodents, such as rats, mice, and chipmunks, are known to carry many diseases. These diseases can spread to people directly, through: - Handling of rodents - Contact with rodent droppings (poop), urine, or saliva - Rodent bites Rodent droppings, urine, and saliva can spread by breathing in air or eating food that is contaminated with rodent waste." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 3 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of three staff (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)- E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 650		

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0 650	Continued From page 4 portion or all of the residents). The findings include: On April 6, 2026, at 10:36 a.m., agent (A)-A stated they were aware of the required contents of employee records. CNS-B CNS-B was hired August 23, 2020, to provide clinical oversite and assisted living services. CNS-B's record lacked documentation of an annual performance evaluation. ULP-E ULP-E was hired July 10, 2025, to provide assisted living services. On April 7, 2026, from 9:15 a.m. to 3:45 p.m., the surveyor observed ULP-E onsite and providing assisted living services. Additionally, the licensee's April 2026 employee schedule indicated ULP-E had worked independently on Sunday, April 5, 2026, from 7:00 a.m. to 7:00 p.m., and was scheduled to work Wednesday, April 8 from 7:00 a.m. to 7:00 p.m. ULP-E's employee record lacked documentation of a 30-day supervision. On April 7, 2026, at 2:35 p.m., CNS-B stated the licensee completed 30-day supervisions, but they were not aware of the need for annual performance evaluations. On April 8, 2026, at 12:49 p.m., licensed assisted living director (LALD)-C stated they were aware of the required contents of employee records and thought annual reviews had been included.	0 650		

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0 650	Continued From page 5 The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records for each person will include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 775		

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0 775	Continued From page 6 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	0 790		

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0 790	Continued From page 8 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 9	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800		

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0 800	Continued From page 10 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37294	A. BUILDING: _____ B. WING _____	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COSMO HOME HEALTHCARE SERVICES	6425 DAWN WAY INVER GROVE HEIGHTS, MN 55076

(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
0 900	Continued From page 12 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract prior to providing housing or assisted living services for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COSMO HOME HEALTHCARE SERVICES	6425 DAWN WAY INVER GROVE HEIGHTS, MN 55076

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0 900	Continued From page 13 has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on March 22, 2025, to receive assisted living services. R2's diagnoses included post-traumatic stress disorder, bipolar disorder, degenerative disease with chronic back pain, and depression. R2's Service Plan (Waiver) - Addendum to Contract, dated March 27, 2025, indicated R2 received assisted living services to include laundry, linen changes, behavior management, medication reminders, medication setup, vital signs and transportation services. R2's record contained a signed contract dated March 27, 2025. R2's record contained documentation of services delivered which indicated R2 had received the following assisted living services prior to execution of an assisted living contract on March 27, 2025: - bathing assistance; - bedmaking; - declutter room; - dressing assistance; - grooming; - housekeeping; - behavior management; - meal assistance, and; - medication reminders. On April 7, 2026, at 2:28 p.m., clinical nurse supervisor (CNS)-B explained that R2 had initially admitted to an affiliated facility under the same	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37294	A. BUILDING: _____ B. WING _____	04/08/2026

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COSMO HOME HEALTHCARE SERVICES	6425 DAWN WAY INVER GROVE HEIGHTS, MN 55076

(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
0 900	Continued From page 14 umbrella of ownership as the licensee. CNS-B stated R2 had moved out of the initial facility and had moved into the current facility on March 27, 2025. CNS-B stated they were under the assumption that R2 moving in between affiliated facilities qualified as a transfer and they would not need to be treated as a discharge and new admission. On April 8, 2026, at 12:53 p.m., licensed assisted living director (LALD)-C stated they were aware that when a resident transferred from an affiliated facility they needed to be treated as a discharge and new admission, but R2 had transferred to their current facility prior to their (LALD-C's) employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37294	A. BUILDING: _____ B. WING _____	04/08/2026

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COSMO HOME HEALTHCARE SERVICES	6425 DAWN WAY INVER GROVE HEIGHTS, MN 55076

(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
0 910	Continued From page 15 by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on March 22, 2025, to receive assisted living services. R2's diagnoses included post-traumatic stress disorder, bipolar disorder, degenerative disease with chronic back pain, and depression. R2's Service Plan (Waiver) - Addendum to Contract, dated March 27, 2025, indicated R2 received assisted living services to include laundry, linen changes, behavior management, medication reminders, medication setup, vital signs, and transportation services. R2's record contained a signed contract dated March 27, 2025. The contract contained the licensee's license number but lacked documentation of the licensee's Health Facility Identification (HFID) number. On April 8, 2026, at 12:53 p.m., licensed assisted living director (LALD)-C stated they were aware the contract needed to list the license's HFID number and would fix it right away.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COSMO HOME HEALTHCARE SERVICES	6425 DAWN WAY INVER GROVE HEIGHTS, MN 55076

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0 910	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment prior to the execution of the assisted living contract/providing services for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01610	Continued From page 17 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on March 22, 2025, to receive assisted living services. R2's diagnoses included post-traumatic stress disorder, bipolar disorder, degenerative disease with chronic back pain, and depression. R2's Service Plan (Waiver) - Addendum to Contract, dated March 27, 2025, indicated R2 received assisted living services to include laundry, linen changes, behavior management, medication reminders, medication setup, vital signs, and transportation services. R2's record contained a signed contract dated March 27, 2025. R2's initial assessment was dated March 25, 2025, which indicated that three days had passed since admission to the licensee. On April 7, 2026, at 2:28 p.m., clinical nurse supervisor (CNS)-B explained that R2 had initially admitted to an affiliated facility under the same umbrella of ownership as the licensee. CNS-B stated R2 had moved out of the initial facility and had moved into the current facility on March 27, 2025. CNS-B stated they were under the assumption that R2 moving in between affiliated facilities qualified as a transfer and they would not need to be treated as a discharge and new	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37294	A. BUILDING: _____ B. WING _____	04/08/2026

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01610	Continued From page 18 admission. The licensee's 6.02 Assessment Schedules policy dated August 1, 2021, indicated an initial assessment would be completed prior to the date on which a prospective resident executes a contract with the facility or the date on which a prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37294	A. BUILDING: _____ B. WING _____	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COSMO HOME HEALTHCARE SERVICES	6425 DAWN WAY INVER GROVE HEIGHTS, MN 55076

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01620	Continued From page 19 of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 20 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on March 22, 2025, to receive assisted living services. R2's diagnoses included post-traumatic stress disorder, bipolar disorder, degenerative disease with chronic back pain, and depression. R2's Service Plan (Waiver) - Addendum to Contract, dated March 27, 2025, indicated R2 received assisted living services to include laundry, linen changes, behavior management, medication reminders, medication setup, vital signs, and transportation services. R2's record contained a signed contract dated March 27, 2025. R2's initial assessment was dated March 25, 2025, three days after R2's admission to the licensee. R2 next assessment occurred on June 21, 2025, 88 days after R2's initial assessment. On April 7, 2026, at 2:28 p.m., clinical nurse supervisor (CNS)-B explained that R2 had initially admitted to an affiliated facility under the same umbrella of ownership as the licensee. CNS-B stated R2 had moved out of the initial facility and had moved into the current facility on March 27, 2025. CNS-B stated they were under the assumption that R2 moving in between affiliated facilities qualified as a transfer and they would not need to be treated as a discharge and new admission.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 21 The licensee's 6.02 Assessment Schedules policy dated August 1, 2021, indicated an assessment would occur no more than 14 calendar days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01630 SS=F	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to initiate a temporary service plan as required, for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on March 22,	01630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01630	Continued From page 22 2025, to receive assisted living services. R2's diagnoses included post-traumatic stress disorder, bipolar disorder, degenerative disease with chronic back pain, and depression. R2's initial assessment was dated March 25, 2025. R2's Service Plan (Waiver) - Addendum to Contract, dated March 27, 2025, indicated R2 received assisted living services to include laundry, linen changes, behavior management, medication reminders, medication setup, vital signs, and transportation services. R2's record lacked any prior service plans specific to the licensee. R2's record contained a document titled Services Delivered dated March 21, 2025, to April 6, 2026. The document indicated R2 recieved the following assisted living services from March 21, 2025, to the date of contract signing on March 27, 2025: - bathing assistance; - bedmaking; - declutter room; - dressing assistance; - grooming; - housekeeping; - behavior management; - meal assistance, and; - medication reminders. On April 7, 2026, at 2:28 p.m., clinical nurse supervisor (CNS)-B explained that R2 had initially admitted to an affiliated facility under the same umbrella of ownership as the licensee. CNS-B stated R2 had moved out of the initial facility and had moved into the current facility on March 27,	01630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01630	Continued From page 23 2025. CNS-B stated they were under the assumption that R2 moving in between affiliated facilities qualified as a transfer and they would not need to be treated as a discharge and new admission. The licensee's 6.07 Service Plan - Temporary policy indicated that if services are initiated prior to an individualized assessment having been completed, the licensee would create a temporary service plan and agreement with the resident for services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630		

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

Cosmo Home Healthcare Services
6425 DAWN WAY
Inver Grove Heights, MN 55076
Dakota County
Parcel:

Phone:

License Info

License: HFID 37294

Risk:
License:
Expires on:
CFPM: Marian Farah
CFPM #: 119969; Exp: 8/25/2026

Inspection Info

Report Number: F7963261058
Inspection Type: Full - Single
Date: 4/7/2026 Time: 10:09:53 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH ESTABLISHMENT REPRESENTATIVE ABDUL SHIRE AND MDH NURSE SURVEYOR ZACH MORTH. DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-DEFINITION OF SAME-DAY SERVICE
-COLD HOLDING
-COOKING OF RAW PROTEINS AND EGGS
-VOMIT/FECAL CLEAN UP
-PEST CONTROL
THIS IS A RESIDENTIAL HOME USING SAME-DAY FOODSERVICE PREPARATION AND HAS A DISHWASHER TO WASH AND SANITIZE DISHES AND UTENSILS.

PHYSICAL FACILITIES INCLUDE WOOD CABINETS, LAMINATE FLOOR, LAMINATE COUNTERTOP AND POPCORN TEXTURED CEILING.

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 F7963261058 from 4/7/2026

Adbdul Shire
PIC

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@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

Cosmo Home Healthcare Services
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F7963261058
Inspection Type: Full
Date: 4/7/2026
Time: 10:09:53 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:**
Location: REFRIGERATOR at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: LUNCH MEAT**; Temperature Process:**
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

Cosmo Home Healthcare Services
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F7963261058
Inspection Type: Full
Date: 4/7/2026
Time: 10:09:53 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:**
Location: DISHWASHER RINSE **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37294016	**Date:** 4/7/2026
Facility Name: Cosmo Home Healthcare	
Facility Address: 6425 Dawn Way, Inver Grove Heights, MN 55076	

☒ **TAG IDENTIFICATION: 0775**

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

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Required egress window openings in rooms of care facilities licensed or registered by the state of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.2, 1104.26.6.1]

   Comments: The facility windows were opened by agent (A)-A during the survey and measured by the surveyor. The egress window in unoccupied resident room 4 was only able to open 20.25 inches wide and 30.5 inches high, with a total openable area of 617.625 square inches when measured during the survey. All resident rooms must have windows with an openable area of at least 648 square inches.

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

   Comments: Unapproved multiplug adapters were in use in the kitchen and basement common room. Unapproved multiplug adapters should be removed.

4. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Several cigarette butts were lying on the ground in the backyard of the property. One cigarette butt was also located on the floor of the garage music studio area. These smoking materials were not properly disposed of, and cigarettes should be properly discarded in a manner that will not pose a fire risk. A trash can was supplied on the rear deck for disposal of smoking materials, but it

contained paper products and other combustible materials. Appropriate receptacles for disposal should be provided and maintained free of combustible materials. All smoking materials, such as cigarettes, should be properly disposed of to avoid the risk of fire.

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

   Comments: Extension cords were in use to power several devices in the garage in lieu of permanent wiring.

☒ **TAG IDENTIFICATION: 0780**

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

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1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: No smoke alarm was present in resident room 3. During the survey, the smoke alarm that was missing from resident room 3 was located in a bag in the garage and reinstalled in the room. Smoke alarms should be maintained in proper working condition in all resident rooms to provide adequate protection.

☒ **TAG IDENTIFICATION: 0790**

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

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1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: An extinguisher was provided in the lower-level kitchen, which did not have current annual service tags. All provided extinguishers should be serviced annually by a licensed contractor.

☒ **TAG IDENTIFICATION: 0800**

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

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments:

   The front walkway was not maintained in a safe condition. The railing was missing from portions of the walkway, boards were rotting or broken, and the side rails were loose. Overall, the walkway was in poor condition and posed a tripping hazard. The walkway should be repaired or replaced and maintained in proper condition.

   The electrical outlet had several circuits which were left open without protective coverings. All circuits should be covered and protected.

   The garage siding was in poor condition with significant damage and pieces broken or missing. A tree was beginning to grow up through the garage foundation and siding which may further deteriorate the integrity of the structure. The garage should be brought to and maintained in proper condition.

   There were piles of ashes from bonfires spread across the lawn. Ashes should be contained within receptacles, and the grounds should be free of burnt materials.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The licensee failed to provide adequate record of evacuation drills for each shift. Provided records indicated that no evacuation drills were conducted on the overnight shift within the last year. Drills should be conducted at least twice per shift per year.

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

   Comments: The licensee failed to show that staff received adequate training on the FSEP. Records provided to the surveyor indicated that staff only received training on the FSEP upon hire, but no further training was provided. Staff should be trained on the FSEP at hire and at least twice a year thereafter.