Electronically Delivered

July 16, 2026

Licensee
3mb health services LLC
1702 13th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL39663016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 17, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

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

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

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

The correction order documentation should include the following:

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

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

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

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

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

(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: SL39663016-0 On June 15, 2026, through June 17, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; 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. 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.	
0 650 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 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included documentation of treatment training and competencies for two of two unlicensed personnel (ULP-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 2 portion or all of the residents). The findings include: On June 16, 2026, at 9:26 a.m., the surveyor observed ULP-B and ULP-C completing personal cares for R1. R1 was observed to have a Purewick urine collection system. On June 17, 2026, at 9:00 a.m., the surveyor observed ULP-C applying Velcro compression wraps to R2 bilateral lower legs. ULP-B ULP-B was hired on December 20, 2023, and provided direct care services to the facility's residents. ULP-B's employee record lacked evidence of training and competency testing for the Purewick urine collection system or for the Velcro compression wraps. ULP-C ULP-C was hired November 6, 2025, and provided direct cares services to the facility's residents. ULP-C's employee record lacked evidence of training and competency testing for the Purewick urine collection system or for the Velcro compression wraps. On June 17, 2026, at 12:13 p.m. licensed assisted living director /clinical nurse supervisor (LALD/CNS)-A stated a nurse from the Purewick company came to the facility and trained the staff on the use of the Purewick system. LALD/CNS-A stated she had not documented the trailing in the employees' records.	0 650		

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0 650	Continued From page 3 On June 17, 2026, at 12:28 p.m., LALD/CNS-A stated she trained and competency tested staff on the Velcro compression wraps. She used the ace wraps competency form to document this; however, the process was unique to the wraps used and was not the same process as the ace wraps. The licensee's undated, Competency Evaluations policy indicated training and competency evaluations would be completed for treatments and delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 4 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP), updated annually, with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee's emergency preparedness binder last reviewed December 10, 2025, lacked the following required content: - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority. - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response - arrangements/contracts to re-establish utility services;	0 680		

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0 680	Continued From page 5 - policy and procedure to address medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, and sewage and waste disposal; - arrangements for transportation of residents - emergency plan training and testing program; and - emergency prep testing requirements. - Missing Resident Policy, failed to be reviewed quarterly as required. On June 17, 2026, at 12:00 a.m., the surveyor reviewed the emergency preparedness plan with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A who stated the above noted content was not in the emergency preparedness plan. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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.	0 800		

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0 800	Continued From page 6 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 June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 7 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more	0 810		

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0 810	Continued From page 8 than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01320 SS=E	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks.	01320		

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01320	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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). The findings include: ULP-B ULP-B was hired on December 20, 2023, and provided direct care services to the facility's residents. On June 16, 2026, at 9:26 a.m., the surveyor observed ULP-B and ULP-C completing personal cares for R1. R1 was observed to have a Purewick urine collection system. ULP-B's employee record lacked evidence of training and/or competency testing for the following required topics: (6) training on the prevention of falls; (9) basic nutrition, meal preparation, food safety, and assistance with eating; and (10) preparation of modified diets as ordered by a licensed health professional.	01320		

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01320	Continued From page 10 ULP-C ULP-C was hired November 6, 2025, and provided direct cares services to the facility's residents. On June 17, 2026, at 9:00 a.m., the surveyor observed ULP-C applying Velcro compression wraps to R2's bilateral lower legs. ULP-C's employee record lacked evidence of training and/or competency testing for the following required topics: (7) standby assistance techniques and how to perform them; and (8) medication, exercise, and treatment reminders. On June 16, 2026, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she could not find the above trainings for ULP-B and ULP-C. LALD/CNS-A stated staff should have completed all required trainings and competency testing. The licensee's undated, Competency Evaluations policy indicated: Training and competency evaluations for all unlicensed personnel must include the following: - Training on the prevention of falls - Standby assistance techniques and how to perform them - Medication, exercise, and treatment reminders - Basic nutrition, meal preparation, food safety and assistance with eating - Preparation of modified diets as ordered by a licensed health professional No further information was provided.	01320		

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01320	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
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 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	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 12 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 observation, interview, and record review, the licensee failed to complete a comprehensive assessment every 90 days as required for two of two residents (R1, 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: R1 was admitted to the facility and began receiving services on July 1, 2023. On June 16, 2026, at 9:26 a.m., the surveyor	01620		

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	39663	A. BUILDING: _____ B. WING _____	06/17/2026

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01620	Continued From page 13 observed ULP-B and ULP-C completing personal cares for R1 and ULP-C. R1's record included the following assessments: - Clinical Update Assessment dated March 4, 2026; - Clinical Update Assessment dated June 4, 2026. This was 92 days between assessments, thus exceeding 90 calendar days. R2 R2 was admitted to the facility and began receiving services on August 25, 2023. On June 17, 2026, at 9:00 a.m., the surveyor observed ULP-C applying Velcro compression wraps to R2's bilateral lower legs. R2's record included the following assessments: - Clinical Update Assessment dated October 6, 2025; - Clinical Update Assessment dated January 6, 2026. This was 92 days between assessments; - Clinical Update Assessment dated April 6, 2026. This was 91 days between assessments. Assessments dated January 6, 2026, and April 6, 2026, both exceeded 90 calendar days. On June 17, 2026, at 10:02 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the assessments are scheduled in the electronic documentation system. Sometimes they land on a weekend or a day she is not in the office so she completes them the next day she is there. The licensee's undated, Comprehensive Resident Assessment policy included "On-going resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	01620		

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01620	Continued From page 14 resident and cannot exceed 90 calendar days from the last date of the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plan modifications were completed and signed when	01640		

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01640	Continued From page 15 the resident's services changed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility and began receiving services on July 1, 2023. On June 16, 2026, at 9:26 a.m., the surveyor observed ULP-B and ULP-C completing personal cares for R1. R1 was observed to have a Purewick urine collection system. R1's service plan dated September 4, 2023, did not include the Purewick urine collection system cares. On June 17, 2026, at 12:13 p.m.. licensed assisted living director/clinical nurse supervisor (LALD/CNS-A stated R1 had recently started the Purewick system, approximately a month prior. LALD/CNS-A stated they did not update the service plan when R1 began using the Purewick system. The staff completed the cares and they were trained by a company representative. The licensee's undated, Service Plan policy indicated the resident shall be advised, orally and in writing, of any changes in type or frequency of services or fee schedule. This advisement shall	01640		

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01640	Continued From page 16 occur as soon as possible after the facility becomes aware of the change. Written notice will be given by making the appropriate changes on the Service Plan and obtaining resident/representative signature or initials. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure there was a system in place for staff to identify medications set up by the nurse for two of two unlicensed personnel (ULP-B, ULP-C) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01750		

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01750	Continued From page 17 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: On June 16, 2026, at 6:59 a.m., the surveyor observed ULP-B administer medications to R3. ULP-B entered R3's room, removed a pill caddy from a plastic box, dumped the medications into a medication cup, and gave the medications to R3. ULP-B documented each medication individually as administered. At that time, the surveyor asked how ULP-B verified the medications. ULP-B stated he should have counted the medications to make sure there were the correct number of pills before administering them, but he forgot. On June 16, 2026, at 7:04 a.m., the surveyor observed ULP-B administer medications to R2. ULP-B entered R2's room, removed a pill caddy from a plastic box, dumped the medications into a medication cup, counted the medications, administered them to R2 and documented each individual medication as administered. On June 16, 2026, at 7:10 a.m., the surveyor observed ULP-B administer medications to R4. ULP-B entered R4's room, removed a pill caddy from a plastic box, dumped the medications into a medication cup, counted the medications, administered them to R4 and documented each individual medication as administered. At that same time, ULP-B stated they learned each of the resident's medications when they were hired and there was nothing in the medication administration record (MAR) that identified the medications they administered. ULP-B stated	01750		

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01750	Continued From page 18 they were trained the medications upon hire and the nurse would tell them if there was a medication change. ULP-B further stated he would be unable to identify the medications in the pill caddy in the event of a refusal, dropped pill, or if there had been a change in the medication due to pharmacy supply change, they would have no way to know. On June 16, 2026, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff were supposed to count the number of pills/capsules on the MAR, and count the number in the pill caddy, administer the medications, and then each medication was signed individually on the MAR. There was no system in place for staff to identify what each medication was. The licensee's undated, Documentation of Medication Administration policy included the following: "The following procedure will be followed for documentation of medication reminders, medication assistance or administration on the Medication Administration Record (MAR) or facility designated form/electronic device: 1. Locate appropriate MAR sheet for the client. Staff will also refer to the medication profile listing the medication name, strength, description, amount to be given and time of day to be given, as well as the purpose of the medication and any special instructions, if applicable. The profile or the MAR will also tell staff what side effects or problems to watch for and report. 2. Staff administering medications will verify the medications are set up correctly before administration to the client by using the medication profile. If there is any question whether the medications have been set up	01750		

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01750	Continued From page 19 accurately, the staff will contact the nurse and will receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse. 3. Staff will administer the medication according to the instructions on the MAR. 4. To document the medication reminder or administration, initial the appropriate box (or enter electronically) on the MAR form to verify the medication has been administered at the appropriate time and date. All staff administering medications to a resident must include the staff person's name/initials and title in the signature box on the MAR or applicable authentication. 5. Staff will document each medication reminder, assistance with medications or medication administration immediately after that task has been performed. 6. Procedures for Extenuating Circumstances or Problems. Staff will document on the MAR any problems with medications and will notify the nurse immediately if problems occur. a. Medication refused - To indicate the medication was refused, circle your initials and write a capital R in the same box on the MAR form. Write on the back of the MAR indicating the date, time and why the client refused the medication or why the client was unable to take the medication. Report the refusal to the nurse. Document notification of the nurse. b. Medication held-To indicate the medication was held, circle your initials and write a capital H in the same box on the MAR form. Include any notes regarding follow up with the nurse on the back of the MAR. c. Medication dropped/soiled - Contact the nurse for instructions or directions for replacing the medication. If a replacement medication is available, administer it per the nurse's instructions. Dispose of the unusable medication	01750		

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01750	Continued From page 20 according to facility policy. d. There is an area located on the reverse side of the MAR form marked "Special Remarks." This is the designated area to document the reason for refusal, held, dropped/spillage of medications." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accurate documentation of medication administration for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 21 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 16, 2026, at 9:26 a.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R1. Medications were set-up in a medication caddy. ULP-C dumped the medications into a medication cup and administered them to R1. ULP-C then signed off on each individual medications on the MAR. The surveyor observed ULP-C sign off Nystatin powder on the MAR; however, it was not observed to be administered. On June 16, 2026, at 1:30 p.m., ULP-B stated he had administered the Nystatin powder at 4:00 a.m. when completing incontinent cares. Since R1 did not require incontinent care at the time of the medication pass, the Nystatin was not administered at that time. On June 16, 2026, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff who complete medication administration should sign off the medication when it is administered to accurately reflect time of administration and who administered it. In addition, R1's physician orders dated June 15, 2026, included diphenhydramine 50 mg one cap by mouth at bedtime (antihistamine for allergies).	01760		

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01760	Continued From page 22 R1's medication administration record (MAR) for June 2026, did not include diphenhydramine. On June 17, 2026, at 9:29 a.m., the surveyor observed R1's medication cards, which showed the diphenhydramine had been punched out of the cards and the medication caddy included the medication in the bedtime spot. On June 17, 2026, at 9:29 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was unsure why the diphenhydramine was not on the MAR, but she contacted the pharmacy who changed something, and now the diphenhydramine was showing up on the MAR for the staff to sign off. LALD/CNS-A stated all medications should be documented as administered. The licensee's undated, Documentation of Medication Administration policy indicated, "Each medication administered by the assisted living facility staff will be documented in the resident's record. The documentation will include the signature and title of the person who administered the medication. Documentation will include the medication name, dosage, date and time administered, and method and route of administration." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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01880	Continued From page 23 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication cart was securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On June 16, 2026, at 6:59 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R3. ULP-B entered R3's room, picked up a plastic box with a door and a three dial combination lock. The numbers were set at 000. ULP-B was able to open the box without changing the numbers. ULP-B did not lock the box after administration and was leaving the room when the surveyor asked about the lock. ULP-B stated it should be locked and locked the box. The unlocked box would have been accessible to resident, staff, and visitors. On June 16, 2026, at 7:04 a.m., the surveyor observed ULP-B administer medications to R2.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 24 ULP-B entered R2's room, picked up a plastic box with a door and a three dial combination lock. The numbers were set at 000. ULP-B was able to open the box without changing the numbers. ULP-B changed the dial prior to returning the box to where it was stored. The unlocked box would have been accessible to resident, staff, and visitors. On June 16, 2026, at 7:10 a.m., the surveyor observed ULP-B administer medications to R4. ULP-B entered R4's room, picked up a plastic box with a door and a three dial combination lock. The numbers were set at 000. ULP-B set box on the bed and the door fell open. ULP-B stated it should be locked at all times, and maybe he forgot earlier when he administered a cream. ULP-B changed the dial prior to returning the box to where it was stored. The unlocked box would have been accessible to resident, staff, and visitors. On June 16, 2026, at 9:26 a.m., the surveyor observed ULP-C provide morning cares and administer medications to R1. ULP-C picked up a plastic box with a door and a three dial combination lock. The numbers were set at 000. ULP-C was able to open the box without changing the numbers. ULP-C did not lock the box after administration and left the room. The unlocked box would have been accessible to resident, staff, and visitors. On June 16, 2026, at 12:38 p.m., the surveyor observed Nystatin powder on the counter in the upstairs bathroom. The Nystatin powder did not have a pharmacy label and did not have a resident name on it. The powder was not locked in a secure location and was accessible to any resident, staff, or visitor.	01880		

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01880	Continued From page 25 On June 16, 2026, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A observed the Nystatin powder in the bathroom with the surveyor and threw it in the garbage can stating it should be labeled and locked up. LALD/CNS-A further stated the medication boxes should be locked at all times when staff are not present in the room. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with open and/or expiration dates for the licensee's one resident with time sensitive medication (R2), and failed to ensure medications were stored with a full pharmacy label 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 26 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 16, 2026, at 12:38 p.m., the surveyor observed Nystatin powder on the counter in the upstairs bathroom. The Nystatin powder did not have a pharmacy label and did not have a resident's name on it. On June 16, 2026, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A observed the Nystatin powder in the bathroom with the surveyor and threw it in the garbage can stating, "It should be labeled. There are two residents who receive Nystatin powder." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	06/17/2026

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3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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01940	Continued From page 27 (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 28 On June 17, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-C putting Velcro compression wraps on R2. R2's Service Plan dated September 14, 2023, included medication administration, blood glucose monitoring and assistance with activities of daily living (ADLs). The Service Plan did not include the Velcro compression wraps. R2's Service Recap Summary (documentation of services) dated June 2026, did not include the Velcro compression wraps. R2's physician orders dated October 1, 2025, did not include Velcro compression wraps. R2's record did not include the Velcro compression wraps or specific instructions for staff application of the wraps. On June 17, 2026, at 10:02 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the Velcro compression wraps should have been on the service plan and on the documentation of services with instructions for the staff. The licensee's undated, Treatment and Therapy Management Plan included: "1. When the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided b. Documentation of specific instructions that relate to providing the treatment or therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	06/17/2026

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3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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01940	Continued From page 29 administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented f. Frequency of supervision of personnel providing the delegated treatment or therapy services g. Verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and	01950		

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3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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01950	Continued From page 30 the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to specify, in writing, specific instructions for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 17, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-C putting Velcro compression wraps on R2. R2's Service Plan dated September 14, 2023, included medication administration, blood glucose monitoring and assistance with activities of daily living (ADLs). The Service Plan did not include the Velcro compression wraps. R2's Service Recap Summary (documentation of services) dated June 2026, did not include the Velcro compression wraps. R2's physician orders dated October 1, 2025, did	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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01950	Continued From page 31 not include Velcro compression wraps. R2's record did not include the Velcro compression wraps or specific instructions for staff application of the wraps. On June 17, 2026, at 10:02 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the Velcro compression wraps should have been on the service plan and on the documentation of services with specific instructions for the staff. The licensee's undated, Treatment and Therapy Management Plan included: "1. When the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided b. Documentation of specific instructions that relate to providing the treatment or therapy administration." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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01960	Continued From page 32 include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document administration of a treatment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 17, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-C putting Velcro compression wraps on R2. R2's Service Plan dated September 14, 2023, included medication administration, blood glucose monitoring and assistance with activities of daily living (ADLs). The Service Plan did not include the Velcro compression wraps. R2's Service Recap Summary (documentation of services) dated June 2026, did not include the Velcro compression wraps.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	06/17/2026

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3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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01960	Continued From page 33 R2's record did not include the Velcro compression wraps or specific instructions for staff application of the wraps. On June 17, 2026, at 10:02 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the Velcro compression wraps should have been on the service plan and on the documentation of services with instructions for the staff. The licensee's undated, Treatment and Therapy Management Plan included: "Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01970	Continued From page 34 Based on observation, interview, and record review, the licensee failed to have a written or electronically recorded order from an authorized prescriber for a treatment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 17, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-C putting Velcro compression wraps on R2. R2's Service Plan dated September 14, 2023, included medication administration, blood glucose monitoring and assistance with activities of daily living (ADLs). The Service Plan did not include the Velcro compression wraps. R2's Service Recap Summary (documentation of services) dated June 2026, did not include the Velcro compression wraps. R2's physician orders dated October 1, 2025, did not include Velcro compression wraps. R2's record did not include the Velcro compression wraps or specific instructions for staff application of the wraps. On June 17, 2026, at 10:02 a.m., licensed	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	06/17/2026

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3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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01970	Continued From page 35 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated there should have been an order for the Velcro compression wraps. The licensee's undated, Treatment and Therapy Management Plan included: "Facility will provide treatment or therapy services to residents under your Assisted Living License. These services will be provided under the orders of an authorized prescriber. The facility will request orders based on the individual resident needs, provide treatments or therapy, education to residents, and document services provided and communication with prescribers." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

3MB Health Services
1702 13TH AVENUE WEST
Shakopee, MN 55379
Scott County
Parcel:

Phone:

License Info

License: HFID 39663

Risk:
License:
Expires on:
CFPM: JULIE S MASSAQUOI
CFPM #: 118282; Exp: 8/12/2026

Inspection Info

Report Number: F1062261132
Inspection Type: Full - Single
Date: 6/16/2026 Time: 11:00 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

INSPECTION COMPLETED ON BEHALF OF HRD REP STACY HAAG.

DISCUSSED MAINTENANCE OF EQUIPMENT, LEFTOVER PROHIBITIONS, SANITIZER TESTING, AND ILLNESS RECORDING.

VINYL COUNTERS HARDWOOD FLOOR, DRYWALL

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 F1062261132 from 6/16/2026

BARBARA ONWONA-APPIAH
OPERATOR

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@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

3MB Health Services
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F1062261132
Inspection Type: Full
Date: 6/16/2026
Time: 11:00 am

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

Food Temperature: Product/Item/Unit: GARLIC IN OIL**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 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

3MB Health Services
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F1062261132
Inspection Type: Full
Date: 6/16/2026
Time: 11:00 am

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39663016-0	**Date:** June 16, 2026
Facility Name: 3MB HEALTH SERVICES LLC	
Facility Address: 1702 13TH AVE W, SHAKOPEE, MN 55379	

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **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 wall in resident bedroom 2 was damaged by an old hospital bed in the room, the damaged area had not been repaired.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; 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 are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided two different FSEP policies in two different binders. When asked which plan the facility was using the LALD/CNS-A stated they were using both. The surveyor advised them that the facility should have one plan to avoid confusion for staff and residents.

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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans 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 plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans 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 facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP didn't include standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

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

   Comments: The licensed assisted living director (LALD/CNS)-A lacked documentation showing any training was offered or training was scheduled for a future date for staff on the fire safety and evacuation plan.

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensed assisted living director (LALD/CNS)-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

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

   Comments: The licensed assisted living director (LALD/CNS)-A lacked documentation showing any evacuation drills occurred. No other information or documentation was provided.