Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered
August 3, 2026

Licensee
Optimal Loving Care
6708 78th Avenue North
Minneapolis, MN 55445

RE: Provisional Conditional License Number 418668
Health Facility Identification Number (HFID) 41173
Project Number(s) SL41173015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **November 1, 2026**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

0470 - 144g.41 Subdivision 1 - Minimum Requirements - $1,000.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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 MDH 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.

CONDITIONAL LICENSE ISSUED:
MDH will issue Optimal Loving Care a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Optimal Loving Care is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** Optimal Loving Care will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Optimal Loving Care must provide the Department:

    i. A list of the names and birthdates of any individuals Optimal Loving Care is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents including:
        1. Name and birthdate of each resident
        2. Current payment source for services
        3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Corrective Action Plan:** Optimal Loving Care will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work

vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Optimal Loving Care is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Optimal Loving Care is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Optimal Loving Care. If MDH determines Optimal Loving Care is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Jess Schoenecker directly at: 651-201-3789 or email at: jess.schoenecker@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41173	A. BUILDING: _____ B. WING _____	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMAL LOVING CARE	6708 78TH AVENUE NORTH MINNEAPOLIS, MN 55445

(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 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: SL#41173015-0 On June 29, 2026, through July 2, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) residents; 2 receiving services under the Provisional Assisted Living license. On July 1, 2026, two immediate correction orders were issued for tag identifications 0470 and 2310. During the course of the survey, the licensee took action to mitigate the imminent risks. Noncompliance remained and the scopes and levels remain unchanged.	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 License Providers. 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 surveyors' 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record (DOR) for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a 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 the residents). The findings include: The licensee's Application for Provisional Assisted Living License, dated April 23, 2024, under the Assisted Living Director section, indicated licensed assisted living director (LALD)-A was listed as the licensee's LALD. LALD-A was licensed on December 16, 2022. The BELTSS website was accessed on June 29, 2026, at 11:35 a.m., and indicated LALD-A was licensed but was not listed as the DOR for the	0 110		

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0 110	Continued From page 2 licensee. On June 29, 2026, at 11:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee was not aware that LALD-A was required to identify themselves as the DOR on the BELTSS website. CNS-B further stated they would have LALD-A log into the BELTSS website and identify themselves as the DOR. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;	0 460		

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0 460	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current 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, 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: On June 29, 2026, at approximately 10:20 a.m., during facility tour, the surveyor observed the facility was a three-level home with a main, upper, and lower level. There was one (1) resident bedroom (BR) on the main level (occupied), three (3) resident BRs on the upper level (one BR occupied), and 1 BR on the lower level (unoccupied). The surveyor also observed no pendants, call light system, or means to request assistance were available in the residents' rooms. On June 29, 2026, at approximately 10:25 a.m., unlicensed personnel (ULP)-F stated the licensee did not have a call light or pendant system the residents could use to summon staff, and the residents would verbally call out to the licensee's staff if needed assistance. On June 29, 2026, at approximately 12:10 a.m., clinical nurse supervisor (CNS)-B stated the	0 460		

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0 460	Continued From page 4 licensee recently purchased a call light system the residents could use to summon staff but had not installed the call system yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure sufficient staffing to meet the reasonably foreseen unscheduled needs of one of two residents (R2) who required a two-person assistance and failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee was licensed for a bed capacity of five (5) residents and had a current census of two (2) residents. STAFFING On June 29, 2026, at 9:00 a.m., during the survey entrance phone conversation, CNS-B stated he worked 12-hour shifts, 5 days in a row, every two weeks at another job in a medical facility providing direct patient care. On June 29, 2026, at 11:50 a.m., during the entrance conference, CNS-B stated the licensee held a provisional assisted living facility license with six (6) staff - licensed assisted living director	0 470	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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0 470	Continued From page 6 (LALD)-A, CNS-B, registered nurse (RN)-C, RN-D, unlicensed personnel (ULP)-E, and ULP-F. The licensee's Employee Roster, undated, indicated the licensee had 2 staff (CNS-B, RN-C) that worked full time and three (3) staff (RN-D, ULP-E, ULP-F) that worked part time. R2 was admitted on December 12, 2025, with diagnoses including post motor vehicle accident and quadriplegia (paralysis of all four limbs and body from the neck down, usually due to spinal cord injury). R2's signed Service Plan dated April 12, 2026, indicated R2 required assistance with transfers. R2's Master Care Plan dated April 13, 2026, indicated R2 required an assistive device (Hoyer lift - full body lift used when a person cannot bear weight) to transfer R2 from his bed to a wheelchair. R2's Assessment dated May 8, 2026, indicated R2 required a Hoyer lift to transfer R2 from his bed to a wheelchair. R2's Individualized Resident Evacuation Plan dated June 12, 2026, indicated R2 required a two-person assist using a mechanical lift (Hoyer) to transfer R2 from his bed to a wheelchair, and assistance with a portable oxygen tank, supplies, and suction device for R2's tracheostomy during an evacuation. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated July 21, 2025, indicated on page 2, the number of ULPs typically scheduled for per shift was 1, and on page 9, transfers with assist of 2 staff were	0 470		

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0 470	Continued From page 7 available. The UDALSA also indicated on page 10, mechanical lift: assist of 2 transfers were available. On June 30, 2026, at 9:05 a.m., RN-C stated R2 required a two-person assist to operate the mechanical lift to transfer R2 from his bed to a chair. On June 30, 2026, at 10:20 a.m., CNS-B acknowledged there were times when a second staff were not available for R2's two-person assist requirement, and the licensee was working on hiring more staff. On June 30, 2026, at 12:35 p.m., RN-C stated she worked another job in a medical facility providing direct patient care but did not provide how many hours a week she worked at the other job. STAFFING PLAN On June 29, 2026, at 10:05 a.m., during a tour of the facility, the surveyor observed a dry erase board mounted on the right side of a metal file cabinet in the living room office area located on the main level. The dry erase board indicated the licensee's staff schedule for the month of June with one (1) licensee staff worked each shift and the shift schedule was 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. On June 29, 2026, at 11:45 a.m., CNS-B stated one staff worked each shift, and the shift schedule was 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. On June 29, 2026, at 11:50 a.m., CNS-B stated they lacked a written staffing plan, and they were	0 470		

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0 470	Continued From page 8 unaware of this requirement. The licensee's Staffing policy dated February 28, 2024, indicated the licensee would prepare and implement a written staffing plan that ensure staffing levels are adequate to address each resident's needs as identified in the resident's assessment, 24 hours a day, seven days a week. The staffing policy also indicated the staffing plan would be reviewed and documented at least twice a year. Minnesota Administrative Rule 4659.0180, Subpart 3 dated August 11, 2021, indicated the clinical nurse supervisor must develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the clinical nurse supervisor must ensure that staffing levels were adequate to address the following: a. each resident's needs, as identified in the resident's service plan and assisted living contract; b. each resident's acuity level, as determined by the most recent assessment or individualized review; c. the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; d. whether the facility has a secured dementia care unit; and e. staff experience, training, and competency. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		

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0 490	Continued From page 9	0 490		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that created opportunities for active participation in the community at large. This had the potential to	0 490		

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	41173	A. BUILDING: _____ B. WING _____	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMAL LOVING CARE	6708 78TH AVENUE NORTH MINNEAPOLIS, MN 55445

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0 490	Continued From page 10 affect all residents of the facility. 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: On June 29, 2026, through June 30, 2026, the surveyor did not observe any activities planned or offered to the residents and residents remained in their rooms. On June 29, 2026, at 10:10 a.m., during a tour of the facility, the surveyor observed a dry erase board mounted in the main level living room. This board indicated a calendar month with days one (1) through 30 and various resident appointments scheduled. The calendar did not indicate any daily social or recreational activities. On June 29, 2026, at 10:15 a.m., unlicensed personnel (ULP)-E stated the board was the licensee's activity schedule for June 2026. On June 29, 2026, at 12:15 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided a daily program of social and recreational activity. On June 30, 2026, at 11:40 a.m., registered nurse (RN)-C stated R3 liked socialization and going outside but lately R3 had decreased interest in these activities. CNS-B also stated there was no	0 490		

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0 490	Continued From page 11 activity schedule written or posted for residents. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated July 21, 2025, on page 13, under the section Supportive Services Available, indicated the licensee had available daily social and recreational services for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 570		

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0 570	Continued From page 12 The licensee held an assisted living license effective December 9, 2024, with an expiration date of December 8, 2025. On June 29, 2026, at 10:15 a.m., during a tour of the facility, the surveyor noted the license was not posted at the facility's main entrance as required. The survey observed the license could not be seen from the facility's main entrance and was displayed behind a wall in the main level living room area. On June 29, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-B acknowledged the license was not posted at the facility's main entrance and stated they were unaware that the license should be posted by the main entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	0 650		

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0 650	Continued From page 13 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 all required content for three (3) of six (6) employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-E, ULP-F). 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: On June 29, 2026, at approximately 11:45 a.m., during the entrance conference, CNS-B stated himself and registered nurse (RN)-C were responsible for all orientation and training requirements for the licensee. CNS-B CNS-B was hired on May 29, 2024.	0 650		

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0 650	Continued From page 14 CNS-B's employee record lacked documentation for a completed Tuberculosis (TB) baseline screening at time of hire. On June 29, 2026, at approximately 3:30 p.m., CNS-B stated they completed the TB baseline screening but they were unable to located the documents. ULP-E ULP-E was hired on March 1, 2026. ULP-E's employee record lacked documentation for completed training and competency in the required 22 areas. ULP-F ULP-F was hired on March 1, 2026. ULP-F's employee record lacked documentation for completed training and competency in the required 22 areas. On June 29, 2026, at approximately 3:35 p.m., ULP-E stated he was trained upon hire by RN-C. On June 30, 2026, at approximately 11:30 p.m., RN-C stated ULP-E and ULP-F completed the training and competency upon hire but was not documented and was unaware of this requirement. The licensee's Personnel Records policy dated February 28, 2024, indicated the licensee would include records of TB baseline screening, training, and competency evaluations in the employee's files. Minnesota Administrative Rule 4659.0190	0 650		

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0 650	Continued From page 15 Subpart 6 published August 11, 2021, indicated all training and competencies must be documented and maintained in each employee's respective record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment. The deficient practice	0 660		

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0 660	Continued From page 16 had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 29, 2026, at approximately 12:05 p.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee had not completed a facility TB risk assessment and was unaware of this requirement. The licensee's Tuberculosis Screening/Prevention policy dated February 28, 2024, indicated the licensee would complete a facility TB risk assessment and update it annually. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 17	0 680		
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 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 have a written emergency preparedness plan (EPP) with all the required content. This 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	0 680		

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0 680	Continued From page 18 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 June 29, 2026, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-B provided a binder and stated the contents were the licensee's EPP. The licensee's undated EPP lacked an individualized plan to include all the required content below: -missing annual review; -missing resident quarterly review; -missing hazard and vulnerability assessment (HVA); -process for emergency preparedness (EP) collaboration; -development of all policies/procedures (P/P) based on HVA; -arrangement of other facilities; -roles under a waiver declared by secretary; -communication plan; and -EP training and testing program. On June 29, 2026, at approximately 3:30 p.m., CNS-B acknowledged the licensee's EPP lacked the above listed required content and stated the licensee was not aware of the HVA and all the requirements of Appendix Z. The licensee's Emergency Preparedness policy dated February 28, 2024, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff	0 680		

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0 680	Continued From page 19 during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated February 28, 2024, indicated the licensee would review the missing resident plan at least quarterly and document any changes to the plan. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	0 700		

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0 700	Continued From page 20 Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm 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: On June 29, 2026, at 10:30 a.m., during a tour of the facility, the surveyor observed in the living room office area, a desk with a hutch that contained shelves. Out in the open, on the second shelf of the left side of the hutch was a white binder labeled Resident Binder. This binder contained documents that included R2's Master Care Plan, dated April 13, 2026, R3's Master Care Plan, dated April 9, 2026, and R3's Medications - Current, dated June 9, 2026. R2 and R3's medical information was not secured by the licensee as it was in the common area accessible to staff, residents, and visitors. R2 was admitted on December 12, 2025, and R3 was admitted on March 9, 2026, respectively. On June 29, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated the resident health and medical information was required to be secured in the locked file cabinet next to the desk in the office area and to only allow staff to access	0 700		

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0 700	Continued From page 21 the information. CNS-B also stated the medical documentation should not have been left out and was unsure why the resident binder was unsecured. The licensee's Privacy of Protected Health Information policy dated February 28, 2024, indicated the licensee would protect the privacy of its residents' personal health information. The licensee's Resident Confidentiality policy dated February 28, 2024, indicated the licensee would keep resident records in a locked file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 730 SS=C	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives,	0 730		

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0 730	Continued From page 22 guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of the resident or the resident's designated representative had received and reviewed the assisted living Bill of Rights (BOR) and the licensee's Uniform Checklist Disclosure of Services (UDALSA) for three of three residents (R1, R2, R3).	0 730		

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0 730	Continued From page 23 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 29, 2026, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated they were responsible for admitting new residents to the facility. R1 R1 was admitted on December 5, 2025, and discharged on December 6, 2026. R1's resident record lacked documentation of the resident or the resident's designated representative had received and reviewed the BOR and the licensee's UDALSA. R2 R2 was admitted on December 12, 2025. R2's resident record lacked documentation of the resident or the resident's representative had received and reviewed the BOR and the licensee's UDALSA. R3 R3 was admitted on March 9, 2026. R3's resident record lacked documentation of the resident or the resident's representative had received and reviewed the BOR and the licensee's UDALSA.	0 730		

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OPTIMAL LOVING CARE	6708 78TH AVENUE NORTH MINNEAPOLIS, MN 55445

(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
0 730	Continued From page 24 On June 30, 2026, at 10:40 a.m., CNS-B stated R1, R2, and R3 received the BOR and the licensee's UDALSA upon admission but did not have documentation that indicated the resident or the resident's designated representative had received the BOR and the UDALSA. CNS-B also stated they were unaware to have evidence of the resident or the resident's designated representative had received the BOR and the licensee's UDALSA. The licensee's Notifications policy dated February 28, 2024, indicated the licensee would provide the resident or resident's representative the BOR and the licensee's UDALSA. The licensee's Clinical Records policy dated February 28, 2024, indicated the licensee would keep in the resident record documentation that the resident or the resident's representative received and reviewed the BOR and the UDALSA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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	0 780		

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0 780	Continued From page 25 sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 780		

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0 780	Continued From page 26 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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	0 810		

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0 810	Continued From page 27 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 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 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information	0 910		

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0 910	Continued From page 28 (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 by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 30, 2026, at approximately 10:05 a.m., clinical nurse supervisor (CNS)-B provided R3's [licensee] Assisted Living Contract and stated the contract was used by the licensee for all residents who would live in the facility. R1 R1 was admitted on December 5, 2025, and	0 910		

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0 910	Continued From page 29 discharged on December 6, 2026. R1's Assisted Living Contract for Assisted Living dated December 25, 2025, lacked inclusion of the licensee's health facility identification (HFID) number. R2 R2 was admitted on December 12, 2025. R2's Assisted Living Contract for Assisted Living dated December 11, 2025, lacked inclusion of the licensee's HFID number. R3 R3 was admitted on March 9, 2026. R3's Assisted Living Contract for Assisted Living dated February 24, 2026, lacked inclusion of the licensee's HFID number. On June 30, 2026, at approximately 10:35 a.m., CNS-B confirmed the licensee's contract lacked the HFID number and stated the licensee was not aware of the requirement to have the HFID number on the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or	0 970		

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0 970	Continued From page 30 unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a 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 the residents). The findings include: On June 30, 2026, at approximately 10:05 a.m., clinical nurse supervisor (CNS)-B provided R3's [licensee] Assisted Living Contract and stated the contract was used by the licensee for all residents who would live in the facility. The licensee's Assisted Living Contract dated February 24, 2026, on page 13, included a section titled Miscellaneous Provisions, sub section Insurance Liability and Release, and read, "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage ...". On June 30, 2026, at approximately 10:35 a.m., CNS-B acknowledged the licensee's assisted	0 970		

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0 970	Continued From page 31 living contract included waivers of liability for health and safety or personal property of the resident. CNS-B stated the liability waivers would need to be removed from the licensee's contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed	01530		

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01530	Continued From page 32 the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all supervisors of direct care staff received two hours of mental illness and de-escalation training within the first 120 working hours of employment as required for one of three registered nurse (RN) employees (clinical nurse supervisor (CNS)-B). 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 29, 2026, at approximately 11:45 a.m., during the entrance conference, CNS-B stated he	01530		

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01530	Continued From page 33 was responsible for all the orientation requirements for the licensee. CNS-B was hired on December 24, 2024, to provide direct care to the residents and supervision to the staff, and worked full time (40 hours a week) for the licensee. CNS-B's personnel record lacked the required two hours of mental illness and de-escalation training within 120 hours of working for the licensee. On June 29, 2026, at approximately 3:15 p.m., CNS-B stated the licensee initially used a different electronic vendor for training and the vendor communicated the training was complete. CNS-B also stated they did not realize the initial mental illness and de-escalating training was not included with the training. The licensee's Dementia Education policy dated February 28, 2024, indicated the licensee would meet the training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff	01650		

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01650	Continued From page 34 who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents' service plan included all required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	01650		

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01650	Continued From page 35 The findings include: On June 29, 2026, approximately 11:50 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated that they developed and maintained the service plan for residents. R2 R2 was admitted on December 12, 2025. On June 30, 2026, at 10:05 a.m., R2's service plan dated April 12, 2026, was provided by CNS-B and indicated as R2's current service plan with services R2 was receiving. R2's service plan lacked the fees for services, identification of staff or categories of staff who would provide the services, and a contingency plan that included the action taken if the scheduled services cannot be provided. R3 R3 was admitted on March 9, 2026. On June 30, 2026, at 10:05 a.m., R3's service plan dated April 9, 2026, was provided by CNS-B and indicated as R3's current service plan with services R3 was receiving. R3's service plan lacked the fees for services, identification of staff or categories of staff who would provide the services, and a contingency plan that included the action taken if the scheduled services cannot be provided. On June 30, 2026, at approximately 10:30 a.m., CNS-B acknowledged R2 and R3's service plans lacked the required content and stated the licensee was unaware that the service plan had to include the fees for services, staff identification,	01650		

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01650	Continued From page 36 and a contingency plan. The licensee's Service Plan policy dated February 28, 2024, indicated the licensee's service plan would include the fees for services, identification of staff providing services, and a contingency plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and 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 medications were stored securely for one of two residents (R2) reviewed with medication management services. 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).	01880		

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01880	Continued From page 37 The findings include: On June 29, 2026, at 10:15 a.m., during a tour of the facility, the surveyor observed four (4) bottles of R2's medication lactulose 10 grams (g) /15 milliliters (ml) solution (non-absorbable sugar used to treat chronic constipation) stored in an unlocked upper cupboard located next to the licensee's locked medication storage cupboard above and to the right of the sink in the kitchen. On June 29, 2026, at 11:50 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication management to all the residents. R2 was admitted on December 12, 2025, with diagnoses including post motor vehicle accident and quadriplegia (paralysis of all four limbs and body from the neck down, usually due to spinal cord injury). R2's signed Service Plan dated April 12, 2026, indicated R2 services provided included medication administration. R2's Assessment dated May 8, 2026, indicated R2's medication management included storage of all R2's medications in a locked medication cupboard located in the licensee's kitchen. R2's signed physician orders dated January 27, 2026, indicated lactulose 10 g/15 ml solution take 30 ml via feeding tube three (3) times a day and hold for more than two (2) stools per day. On June 29, 2026, at 12:15 p.m., CNS-B acknowledged R2's lactulose 10 g/15 ml solution was not stored properly and stated they placed this medication in the unsecured cabinet	01880		

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01880	Continued From page 38 yesterday and did not give a reason why it was unsecured. The licensee's Storage/Control of Medications policy dated February 28, 2024, indicated the licensee would assure that resident medications would be stored in a secured locked compartment. No further information was 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 monitor expired medications 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).	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41173	A. BUILDING: _____ B. WING _____	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMAL LOVING CARE	6708 78TH AVENUE NORTH MINNEAPOLIS, MN 55445

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01890	Continued From page 39 The findings include: On June 29, 2026, at 10:15 a.m., during a tour of the facility, the surveyor observed in the kitchen area on the main level a full-size refrigerator that contained two bottles of R2's medication amoxicillin 400 milligrams (mg)/five (5) milliliter (ml) suspension (antibiotic to treat bacterial infections). The two medication bottles of R2's amoxicillin were expired on May 10, 2026. On June 29, 2026, at 11:50 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication management to all the residents. On June 29, 2026, at 12:20 p.m., the surveyor reviewed R2's amoxicillin medications that were stored in the licensee's refrigerator in the kitchen with CNS-B and they confirmed R2's amoxicillin medications were expired. CNS-B did not give a reason why the two bottles of R2's expired amoxicillin were not disposed of. R2 was admitted on December 12, 2025, with diagnoses including post motor vehicle accident and quadriplegia (paralysis of all four limbs and body from the neck down, usually due to spinal cord injury). R2's signed Service Plan dated April 12, 2026, indicated R2 services provided included medication administration. R2's Assessment dated May 8, 2026, indicated R2's medication management included monitoring of R2's medication supply per physician's order.	01890		

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OPTIMAL LOVING CARE	6708 78TH AVENUE NORTH MINNEAPOLIS, MN 55445

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01890	Continued From page 40 R2's signed physician orders dated May 7, 2026, indicated amoxicillin 400 mg/5 ml suspension: 1,000 mg via feeding tube every eight (8) hours and stop taking on May 9, 2026. The licensee's Disposition and Disposal of Medications policy dated February 28, 2024, indicated the licensee would dispose of expired resident medications. Manufacturer storage directions for amoxicillin 400 mg/5 ml suspension dated April 2026, indicated to keep refrigerated and discard any unused portion after 14 days since the drug loses potency after that time. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of two residents (R2) who utilized hospital side rails. This practice resulted in a level three violation (a	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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	41173	A. BUILDING: _____ B. WING _____	07/02/2026

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02310	Continued From page 41 violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On June 29, 2026, at approximately 10:15 a.m., during facility tour, the surveyor observed a hospital style bed in R2's room with raised bilateral (both sides of the bed) upper ½ side rails attached. The bed's wheels were in a locked position, and the bed did not move when the surveyor attempted to move the bed, but the attached side rails were loose and moved side to side when the surveyor moved the side rails. R2 was admitted on December 12, 2025, with diagnoses including post motor vehicle accident and quadriplegia (paralysis of all four limbs and body from the neck down, usually due to spinal cord injury). R2's Master Care Plan dated April 13, 2026, indicated R2 needed full assistance and total care with bathing, dressing, grooming, nutrition, toileting, housekeeping, repositioning, and transfers. R2's registered nurse (RN) bed safety assessment dated May 8, 2026, indicated there was a hospital bed with two (2) upper side rails in use for R2 to prevent any possibility of a fall during cares, but the hospital bed safety zone assessment was not applicable as R2 had no side rails in use.	02310		

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	41173	A. BUILDING: _____ B. WING _____	07/02/2026

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02310	Continued From page 42 R2's medical record lacked documentation: - specific measurements for zones of entrapment per the Food and Drug Administration (FDA) guidelines; - if the side rails were FDA compliant; and - physical inspection of the bed rails and mattress for areas of entrapment, stability, and correct installation. On June 30, 2026, at 9:30 a.m., RN-C confirmed R2's bilateral side rails were loose and was unsure why. On June 30, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-B acknowledged the bed safety assessment lacked documentation of the hospital bed rails zone measurements and stated they were unaware of the bed rails zone measurements requirement. The licensee's Side Rail Use policy dated February 28, 2024, indicated the licensee would ensure that the side rails used by residents are of a safe design, properly maintained, and met FDA safety guidelines. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website dated April 17, 2026, indicated documentation about a resident's hospital side rails should include specific measurements of zones of entrapment, whether the side rails are FDA compliant, and physical inspection of bed rails and mattress for areas of entrapment, stability, and correct installation. The FDA A Guide to Bed Safety, revised April 2010, included the following information: When bed rails are used, perform an on-going assessment of the patient's physical and mental	02310		

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02310	Continued From page 43 status, closely monitor high-risk patients. The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a	03090		

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03090	Continued From page 44 violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On June 29, 2026, at 9:55 a.m., upon arrival at the facility, the surveyor observed a camera installed outside the facility on the siding above the garage door, and at the main entrance accessible by visitors, the entrance lacked the required notice for electronic monitoring. On June 29, 2026, at 10:10 a.m., during a tour of the facility, the surveyor observed a camera on the mantle of the fireplace located in the main level living room. On June 29, 2026, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee was unaware of the required electronic monitoring verbatim notice posting at the facility entrance. The licensee's Electronic Monitoring policy dated January 31, 2024, indicated the licensee would post the required electronic monitoring verbatim notice at the facility entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Optimal Loving Care
6708 78th Ave. N.
Mineapolis, MN 55445
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41173

Risk:
License:
Expires on:
CFPM: Dieudonne Wang Mukete
CFPM #: 61089; Exp: 8/27/2028

Inspection Info

Report Number: F1063261161
Inspection Type: Full - Single
Date: 6/29/2026 Time: 2:15 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection was completed with MDH Health Regulation Division Nurse Evaluator Carl Samrock conducting the site survey.

Discussed highly susceptible populations, handwashing, glove use, same day food service, food storage & temperature control, date marking, ware washing, test kits, vomit cleanup procedures, and employee illness policy.

TEMPERATURES (DEGREES F):
Refrigerator: Hot Dogs 39
Dish Machine Utensil Surface: 169.2

The facility has a residential kitchen. Food must be prepared for same day service only. The kitchen has tile floors, smooth painted ceilings & walls with tile backsplash, smooth countertops, and wooden cabinetry. All found to be in good condition.

Equipment includes a two-basin sink with one compartment designated for handwashing, ANSI residential fridge/freezer & dish machine, and upright freezer unit.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1063261161 from 6/29/2026

Dieudonne Mukete
Director

Laura Yang,
Public Health Sanitarian 1

651-201-3581
laura.yang@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41173015-0	**Date:** 6/30/2026
Facility Name: OPTIMAL LOVING CARE	
Facility Address: 6708 78th Ave. N. Minneapolis, MN 55445	

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: During the survey tour, the surveyor observed that all smoke alarms throughout the facility had been removed from their mounting brackets. When questioned, the licensed assisted living director (LALD)-A stated that the smoke alarms had not been operating as an interconnected system and that he was in the process of reinstalling and reconnecting them when the surveyor arrived. LALD-A installed and tested the smoke alarms to verify interconnection while the surveyor was onsite.

☒ **TAG IDENTIFICATION: 0810**

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

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.