Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 29, 2025

Licensee
Mercy Link LLC
3149 Columbus Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL34232016

Dear Licensee:

On September 24, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 22, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 22, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 22, 2025, found not corrected at the time of the September 24, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $500.00

The details of the violations noted at the time of this follow-up survey completed on September 24, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Renee L. Anderson at 651-201-5871.

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

Sincerely,

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	34232	A. BUILDING: _____ B. WING _____	R 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY LINK LLC	3149 COLUMBUS AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL34232016-1 On September 22, 2025, through September 24, 2025, the Department of Health conducted a licensing order follow up survey to follow-up on orders issued pursuant to a survey completed May 22, 2025. At the time of the follow-up survey there were three residents, all receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following order was reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	{0 480}		

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{0 480}	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Was not reviewed during the follow-up survey.	
{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	{0 680}		

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{0 680}	Continued From page 3 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: Was not reviewed during follow-up survey.	{0 680}	Was not reviewed during follow-up survey.	
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly 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). Findings include:	{0 775}		

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{0 775}	Continued From page 4 On a facility tour on September 23, 2025, from 1:15 p.m. to 1:45 p.m., with unlicensed personnel/ housing manager (ULP/HM)-D, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: ELECTRICAL EQUIPMENT AND FIXTURE MAINTENANCE The main electrical panel on the wall in resident sleeping room 5 had the cover altered. The main electrical panel cover was cut off to make it shorter at the top and bottom of the door. It was explained that manufactured electrical panels are required to be maintained as designed and installed at the time of construction approval and shall not have the design altered. During an interview on September 23, 2025, at 1:30 p.m., ULP/HM-D, stated they purchased a new cover, but it did not fit. They continue to work at getting the correct cover or will hire an electrician to repair the panel cover.	{0 775}		
{0 800} SS=E	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 5 This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	{0 810}		

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{0 810}	Continued From page 6 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	

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July 24, 2025

Licensee
Mercy Link LLC
3149 Columbus Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL34232016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 22, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, 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 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $7,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

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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: SL34232016-0 On May 19, 2025, through May 22, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; two residents receiving services under the Assisted Living Facility license. An immediate correction order was identified on May 19, 2025, issued for SL34232016-0, tag identification 0470. An immediate correction order was identified on May 20, 2025, issued for SL34232016-0, tag identification 1290.	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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 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 observation, interview and record review, the licensee failed to ensure the licensed assisted living director was listed as the Director of Record (DOR) for the licensee. 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 has no potential to cause more than a minimal impact on the client/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: Licensed assisted living director (LALD)-A started employment on September 17, 2018, and began providing assisted living services August 1, 2021. On May 19, 2025, at 11:00 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C identified LALD-A as the current LALD for the facility. CNS-C added LALD-A was out of the country at this time but could be reached by phone, and owner/ LALD-B would also be available by phone if needed. On May 19, 2025, at 11:45 a.m., during a tour of	0 110		

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0 110	Continued From page 2 the facility, the surveyor observed LALD-A's assisted living director license, expiration date October 31, 2025, posted on the wall. On May 20, 2025, at 12:30 p.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A held a current assisted living director license. The BELTSS website indicated LALD-A was the DOR for health facility identification (HFID) 40266, 35990, 40266, and 35138. BELTSS indicated LALD-A was no longer the DOR for the surveyed facility, HFID 34232, as of July 22, 2024. The Minnesota BELTSS website indicated LALD-B was currently the DOR for a sister-facility, HFID 36792, but was no longer the DOR for the surveyed facility, HFID 34232, as of October 31, 2024. On May 20, 2025, at 1:18 p.m. the MN BELTSS Director of Assisted Living and Education stated via e-mail, that LALD-A was no longer DOR for the facility once a shared license was issued to LALD-B on July 22, 2024. The BELTSS representative further stated LALD-B's shared license expired October 31, 2024, and was not renewed. On May 22, 2025, at 2:00 p.m., LALD-A stated per telephone conversation, their family owned several Assisted Living facilities, and this was the most recently added, so might be the reason it was overlooked. LALD-A stated she was not aware a DOR was not listed for the licensee. LALD-A stated when they renewed the LALD license they thought the DOR would be renewed at the same time. No further information was provided.	0 110		

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	34232	A. BUILDING: _____ B. WING _____	05/22/2025

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0 110	Continued From page 3 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure they had one	0 470	The licensee submitted an acceptable plan of correction; the scope and severity	

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0 470	Continued From page 4 or more persons available 24 hours per day, seven days per week, who were awake and responsible for responding to the requests of residents for assistance with health or safety needs. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 May 19, 2025, at 11:55 a.m., the licensee's staff schedule was observed on a cork board in a common area of the facility. The schedule, dated "May 1st-June 1st" indicated one unlicensed personnel (ULP) was scheduled to work each of three shifts during the week: -morning 8:00 a.m.- 4:00 p.m. -afternoon 4:00 p.m.-11:00 p.m. -overnight 11:00 p.m.-8:00 a.m. The schedule further indicated one ULP was scheduled on the weekend, to complete a 48-hour shift. On May 19, 2025, at 12:21 p.m., the owner and acting licensed assisted living director (LALD)-B, stated the licensee only had one 48-hour shift during the weekend. LALD-B further explained staff were, previously, not allowed to sleep in the facility, but due to difficulty hiring and keeping staff, the licensee now allowed staff to take in-house breaks and to sleep at the facility while	0 470	remain at level 3, widespread.	

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0 470	Continued From page 5 residents slept, during overnight shifts until another ULP could be hired for weekend employment. On May 19, 2025, at 12:30 p.m., R2 stated only one employee worked over the entire weekend. R2 stated they saw the employee sleeep in the living room, in front of the television on an air mattress brought up from the basement. On May 19, 2025, at 12:35 p.m., R1 stated one staff was physically at the the facility throughout the weekends. R1 stated staff slept on mattress in front of the couch, and, "They sleep when we sleep." R1 further stated the mattress was stored in the basement. On May 19, 2025, at 12:40 p.m., the surveyor observed the basement level of the facility, with housing manager/ unlicensed personnel (ULP)-D and R1. In a bedroom, a very light mattress was observed leaning against the wall. In the closet of the bedroom was a rolled up set of a top and bottom sheet and a pillow. R1 stated they were not completely sure this was the mattress being used because it was covered. R1 stated the sheets in the closet "were definitely" the ones they had previously seen used by the employee. On May 19, 2025, at 3:36 p.m., LALD-A stated it was difficult to employ consistent weekend staff. LALD-A stated the licensee planned to hire an employee that was able and willing to work weekends until a permanent replacement was found. The licensee's Staffing Plan policy, dated May 26, 2020, indicated: -the purpose of this policy was to ensure the licensee maintains all qualified staffing levels in	0 470		

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0 470	Continued From page 6 alignment with Minnesota Statutes 144G.80 ensuring the safety, health and well-being of all residents. -the licensee was committed to providing sufficient staffing and awake staff at all times to meet the scheduled and unscheduled needs of residents. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and	0 480		

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0 480	Continued From page 7 clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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	0 480		

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0 480	Continued From page 8 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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	0 680		

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0 680	Continued From page 9 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 (EP) plan with all the required content. This had the potential to affect all current 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 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: The licensee's EP plan, undated, lacked the following required content: -be updated annually, must document date of review and any updates made to the plan based on the review, -consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies, -identify at risk population needs like evacuation assistance, maintaining independence, communication, transportation, supervision and	0 680		

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0 680	Continued From page 10 medical care. -develop policies and procedures (P/P) for system to track the location of staff and residents, -identify which staff would assume specific roles in another's absence through succession planning and delegation of authority, -P/P (policies and procedures) for at minimum food, water, and pharmaceutical supplies. -P/P addressing volunteers -P/P medical documents -P/P long term care family notifications; and -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). On May 21, 2025, at 11:30 a.m., house manager/ unlicensed personnel (ULP)-D stated he was in charge of the program. ULP-D stated "This is all we have." On May 22, 2025, at 2:00 p.m., licensed assistant living director, (LALD)-A stated the licensee would develop an EP plan to address the needs of resident and staff to ensure their safety and well-being. The licensee's Emergency Preparedness policy, revised April 23, 2025, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. The plan considered the organization ' s commitment to provide services while ensuring the safety of its employees and residents. The licensee would implement the emergency management program as soon as the	0 680		

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0 680	Continued From page 11 agency became aware of the existence of an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly 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: On a facility tour on May 21, 2025, from 12:15 a.m. to 1:30 p.m., with housing manager/ unlicensed personnel (ULP)-D, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511:	0 775		

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0 775	Continued From page 12 REQUIRED EXIT DOOR LOCKING The main front door required exit was provided with 3 separate locking devices requiring operation to release the door in order to exit. It was explained that required exit doors in this occupancy type shall not have more than two separate locking devices to operate the door to release to exit the building in the event of a fire or similar emergency. EMERGENCY ESCAPE AND RESCUE WINDOW MAINTENANCE The emergency escape and rescue window in unoccupied resident sleeping room 5 was missing the window opening crank hardware used to open the window in the event of a fire or similar emergency. The window crank hardware is required to be installed at all times, in order for occupants to open the window in the event of a fire or similar emergency. There was vegetation and trees growing in the window well and coming into contact with the window while opening. The window wells shall be maintained clear of vegetation and obstructions that prevent the full and immediate use of the emergency escape and rescue window. SMOKE ALARM MAINTENANCE The battery-operated smoke alarm installed on the wall near the second-floor public bathroom	0 775		

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0 775	Continued From page 13 did not sound when tested by ULP-D. ELECTRICAL EQUIPMENT AND FIXTURE MAINTENANCE The main electrical panel on the wall in resident sleeping room 5 had the cover altered. The main electrical panel cover was cut off to make it shorter at the top and bottom of the door. It was explained that manufactured electrical panels are required to be maintained as designed and installed at the time of construction approval and shall not have the design altered. The glass light fixture cover on the ceiling was missing the cover provided by the manufacture and had 2 missing light bulbs. It was explained electrical light fixtures are required to be maintained with all covers installed at the time of installation and construction approval. It was also explained light bulbs are required to be maintained in place in the socket to prevent contact with electrical power by a building occupant. RESIDENT ROOM NUMBER IDENTIFICATION It was observed there was not room numbers installed on or adjacent to the doors of resident rooms 2 and 4 to identify the location of the resident room in the event of a fire or similar emergency. During the facility tour ULP-D verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 14 days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to	0 780		

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0 780	Continued From page 15 directly 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: On a facility tour on May 21, 2025, from 12:15 a.m. to 1:30 p.m., with housing manager/ unlicensed personnel (ULP)-D, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms in resident sleeping room 5 when tested by ULP-D. The alarms provided on the second floor were also tested by ULP-D, and not interconnected with the alarms provided on the main floor and in the basement. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. It was also observed the building had existing hardwired (receiving power from the building electrical system) and interconnected smoke alarms installed at the time of construction that were removed and replaced with battery power only alarms. All existing hardwired smoke alarms are required to be maintained as hardwired. All required existing hardwired alarms are required to be interconnected to all other alarms installed	0 780		

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0 780	Continued From page 16 throughout the facility so activation of one alarm activates all alarms. During the tour the smoke alarms were tested and ULP-D verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and 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	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34232	A. BUILDING: _____ B. WING _____	05/22/2025

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0 790	Continued From page 17 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 a facility tour on May 21, 2025, from 12:15 a.m. to 1:30 p.m., with housing manager/ unlicensed personnel (ULP)-D, it was observed that the required fire extinguisher on the main floor in the kitchen had a manufacture date of 2020 and no records were available of required annual service of the extinguisher. There was also no documentation available indicating the fire extinguishers were inspected monthly. The surveyor explained that at least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility in accordance with Minnesota State Fire Code Section 906. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During the facility tour, ULP-D verified the above listed observations while accompanying on the tour.	0 790		

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0 790	Continued From page 18 TIME PERIOD FOR CORRECTION: Two (2) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of 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 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:	0 800		

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0 800	Continued From page 19 On a facility tour on May 21, 2025, from 12:15 a.m. to 1:30 p.m., with housing manager/ unlicensed personnel (ULP)-D, the surveyor made the following observations of facility disrepair: ELECTRICAL FIXTURE MAINTENANCE It was observed the light fixture was missing the manufacturer-provided cover and light bulbs exposing electrical power sockets to occupants. There was a light bulb missing exposing the electrical power socket in the light fixture on the wall above the bathroom sink in the basement bathroom. It was explained that electrical fixtures are required to be maintained with covers and bulbs as installed at the time of construction to prevent contact with the electrical power sockets. The bathroom exhaust fan in the basement bathroom did not operate when the wall switch was turned on and the screen and cover were plugged with dust and lint. It was explained that bathroom exhaust fans are required to be maintained in working condition and covers clean to allow the fan to operate as designed and installed at the time of construction. WATER HEATER MAINTENANCE There was water present under and around the water heater in the basement mechanical room. It was observed the water heater drain was dripping causing the presence of water on the floor under the water heater.	0 800		

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0 800	Continued From page 20 It was explained the water heater is required to be maintained free of leaks that cause water damage to equipment and the building structure. CEILING AND WALL MAINTENANCE There was damage from moisture to the wall above the shower in the second-floor bathroom. There was also damage from water to the ceiling in resident sleeping room 5. There was damage to the wall and holes in the drywall behind the door in the second-floor bathroom. CLOSET DOOR MAINTENANCE The hardware was broken, and the bi-fold doors did not operate as designed and installed in resident sleeping rooms 2 and 4. During the facility tour, ULP-D verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 21 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 develop the fire safety and evacuation plan with required content, and provide required training and drills. This had the potential to directly 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	0 810		

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0 810	Continued From page 22 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 May 21, 2025, at 11:45 a.m., housing manager/ unlicensed personnel (ULP)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated April 23, 2025, failed to include the following: The location and number of resident sleeping rooms were not identified on the posted FSEP evacuation floor plan on second floor, first floor and the basement. The surveyor explained to ULP-D, that resident sleeping room numbers are required to be included on the evacuation floor plan in order to direct building occupants to an exit in the event of a fire or similar emergency. The available FSEP included standard resident evacuation procedures, but failed to provide specific individualized unique needs of residents for evacuation. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. The individual resident unique needs for evacuation are required to be readily available to all staff, at all times within the facility, for use in	0 810		

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0 810	Continued From page 23 responding to a fire or similar emergency. During an interview on May 21, 2025, at 12:00 p.m., ULP-D. stated the resident room numbers were not identified on the posted fire evacuation floor plans and individual resident evacuation status unique needs for evacuation were not developed and kept available within the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation the required training was completed by employees. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the training was provided to residents as required. During an interview on May 21, 2025, at 12:05 p.m., ULP-D stated documentation was not available indicating employees and residents received training as required. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation that 3 fire evacuation drills were completed in January, March and May of 2025 only.	0 810		

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0 810	Continued From page 24 The documentation provided indicated the drills were completed at 1:00 p.m. in January, 3:00 p.m. in March and 9:30 a.m. in May. The documentation provided did not indicate the shift each drill was completed in. During an interview on May 21, 2025, at 12:15 p.m., ULP-D stated the only documentation available was provided and documentation was not available indicating evacuation drills were completed every other month and twice per year per shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	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 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 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	0 970		

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0 970	Continued From page 25 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: R1 was admitted to the facility on June 28, 2024, and had diagnoses including schizophrenia and diabetes mellitus type two. R1's Service Plan Agreement dated, June 28, 2024, indicated R1 received services including assistance with medication management. R1's Assisted Living Contract signed June 24, 2024, included the following language indicating waivers of liability: Miscellaneous Provisions: 1. Insurance liability and release "The resident acknowledges that Mercy Link is not an insurer of the resident's person or property. The resident agrees that Mercy Link will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of Mercy Link or its employees or agents. The resident hereby releases Mercy Link from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of Mercy Link or its employees or agents."	0 970		

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0 970	Continued From page 26 On May 22, 2025, at 2:30 p.m., licensed assisted living director (LALD)-A stated they were not aware the waiver was in resident contracts. LALD-A further stated, the licensee would make all needed corrections for current and future residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study, prior to providing services, for	01290	The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, widespread.	

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01290	Continued From page 27 two of five employees (unlicensed personnel (ULP)-F, ULP-G). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: ULP-F ULP-F was hired January 28, 2025, to provided direct care services to the licensee's residents. The licensee's employee schedule posted for "May 1, through June 1", indicated ULP-F was scheduled for a 48-hour shift each weekend, Saturday through Sunday. ULP-F's employee record lacked evidence of a cleared background study completed prior to having direct contact with residents. The licensee's background study roster in the DHS NETStudy 2.0 database (an online system to process and track background studies), printed May 20, 2025, indicated the licensee had initiated a background study for ULP-F on May 20, 2025, during the time of the survey. The NETStudy roster indicated the background study for ULP-F was "in-process" and that supervision was required. ULP-G ULP-G was hired August 15, 2024, to provide	01290		

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01290	Continued From page 28 direct care services to the licensee's residents. The licensee's employee schedule posting "May 1, through June 1", indicated ULP-G worked 4:00 p.m., through 11:00 p.m., Monday through Friday, each week. ULP-G's employee record lacked evidence of a cleared background study completed prior to having direct contact with residents. The licensee's background study roster in the DHS NETStudy 2.0 database, printed May 20, 2025, indicated the licensee had initiated a background study for ULP-G on May 20, 2025, during the time of the survey. On May 20, 2025, at 1:30 p.m., licensed assisted living director (LALD)-A explained the licensee's owner had eight other facilities which were converted to community residential services (CRS) facilities. LALD-A stated staff moves from one facility to another when needed for staffing. LALD-A stated she was not aware that each employee needed to have a background study affiliated with each license/HFID. LALD-A stated the licensee planned to complete monthly employee record audits and ensure the hiring process was properly completed in the future. The licensee's Background Checks policy, dated August 15, 2016, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees would not have independent, unsupervised contact with tenants or clients of the licensee. No employee would have independent direct contact with any tenants or clients until acceptable result(s) of the background study were received. The licensee would not employ individuals whose	01290		

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01290	Continued From page 29 results of the background study indicate disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
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 medications were maintained including the opened date for time sensitive medication storage 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) 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 had diagnoses including schizophrenia and diabetes mellitus type 2.	01890		

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01890	Continued From page 30 R1's Service Plan Agreement dated, June 28, 2024, indicated R1 received services including assistance with medication management. R1's medication management plan, dated June 28, 2024, indicated staff was responsible for medication storage and security, every medication pass. On May 20, 2025, at 3:53 p.m., the surveyor observed the licensee's medication storage with housing manager/ unlicensed personnel (ULP)-D. R1's unopened insulin was observed in the licensee's unlocked food refrigerator located in the kitchen area of the facility. The medications included: -one box of five pens plus an opened box of one, Novolog (fast-acting insulin, for diabetes) Flexpen 100u/ml -one box of five pens, Lantus (long-acting insulin) Solostar -one box of four pens, Ozempic (for blood glucose control) pre-filled pen -one box of five pens, Basaglar (long-acting insulin) Kwikpen ULP-D stated the licensee stored unopened insulin in the vegetable bins within the resident food refrigerator. ULP-D further stated the refrigerator was never locked. On May 22, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-C stated the licensee would correct this situation by purchasing a small refrigerator for medical purposes only. Staff would be instructed to keep it always locked when in use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34232	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY LINK LLC	3149 COLUMBUS AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 31 days	01890		

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

Mercy Link LLC
3149 Columbus Avenue South
Minneapolis, MN 55407
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34232

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

Inspection Info

Report Number: F1013251011
Inspection Type: Full - Single
Date: 5/19/2025 Time: 01:00:00 PM
Duration: 45 minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 4
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision
2-102.11ABCQ *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0030ABCQ The person in charge must be able to demonstrate their knowledge to the inspector of the following factors associated with employee health and the transmission of foodborne disease: symptoms of illness frequently associated with foodborne diseases; food worker illness reporting requirements; and medical conditions requiring exclusion of an employee from work or the restriction of their work duties.
COMMENT: OPERATOR WAS NOT AWARE OF STAFF ILLNESS POLICY, ILLNESS REPORTING REQUIREMENTS, AND RECORDING STAFF ILLNESS. COMPLY WITH RULE. DISCUSSED STAFF ILLNESS POLICY REQUIREMENTS AND PROVIDED MDH GUIDANCE.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: NO MN CFPM IS EMPLOYED AT THE FACILITY. COMPLY WITH RULE. MN CFPM INFORMATION WAS PROVIDED.
Comply By: 7/21/2025 Originally Issued On: 5/19/2025

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPEN PACKAGES OF READY-TO-EAT DELI MEAT WITHOUT DATE MARKS WERE LOCATED IN THE REFRIGERATOR. PER STAFF THE DELI MEATS WERE OPENED MORE THAN 1 DAY PRIOR TO INSPECTION. COMPLY WITH RULE. DISCUSSED DATE MARKING PROCEDURES WITH STAFF AND REQUESTED FOOD BE DATE MARKED.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12 *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: 5/19/25 REPEAT
NO FOOD PROBE THERMOMETER WAS AVAILABLE. TCS FOODS ARE STORED AND COOKED ONSITE. RAW MEATS AND EGGS ARE COOKED ONSITE. COMPLY WITH RULE. DISCUSSED THERMOMETER USE WITH STAFF. ORDER WAS ISSUED ON 5/30/23.

OPERATOR EMAILED THE PURCHASE RECEIPT FOR A THERMOMETER.
Comply By: Complied On Site Originally Issued On: 5/19/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: HOT WATER DISH MACHINE IS USED TO WASH AND SANITIZE WARE. NO TEST KIT MEETING THE ABOVE REQUIREMENTS WAS AVAILABLE. COMPLY WITH RULE.

OPERATOR EMAILED THE INVOICE FOR PURCHASE OF THERMAL TEST KIT.
Comply By: Complied On Site Originally Issued On: 5/19/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.12 *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.
COMMENT: FOOD DEBRIS BUILDUP WAS LOCATED INSIDE THE MICROWAVE AND OVEN. COMPLY WITH RULE. DISCUSSED CLEANING PROCEDURES WITH STAFF.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: 5/19/25 REPEAT
PLATES AND CUPS WERE ON A DRYING RACK ON THE KITCHEN COUNTER. PER STAFF THE WARE WAS WASHED WITH WATER AND SOAP. COMPLY WITH RULE. DISCUSSED WARE WASHING PROCEDURES WITH STAFF AND REQUESTED WARE BE SANITIZED IN THE DISH WASHER. ORDER WAS ISSUED ON 5/30/23.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator M. Bruess.

The establishment has a residential kitchen and serves food prepared that day. The kitchen has wood cabinets, wood floor, smooth painted walls, laminate counter top, and a textured painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

Residential dish machine is used to wash ware. Run the dish machine on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

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 F1013251011 from 5/19/2025

Jerry Malloy

Guled Jama
ULP

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@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

Mercy Link LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1013251011
Inspection Type: Full
Date: 5/19/2025
Time: 01:00:00 PM

Food Temperature: Product/Item/Unit: Turkey**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Waffle**; Temperature Process:** Cold-Holding
Location: Freezer at 22 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

Mercy Link LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1013251011
Inspection Type: Full
Date: 5/19/2025
Time: 01:00:00 PM

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