Electronically Delivered

May 5, 2026

Licensee
New Bridge Care LLC
10 92nd Avenue Northeast
Blaine, MN 55434

RE: Project Number(s) SL35866016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 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 - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

To submit a hearing request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	35866	A. BUILDING: _____ B. WING _____	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIDGE CARE LLC	10 92ND AVENUE NE BLAINE, MN 55434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35866017-0 On March 9, 2026, through March 11, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license. An immediate correction order was identified on March 10, 2026, issued for SL35866016-0, tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level 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 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: 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 11, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. 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 require any resident to include and pay for meals as a part of their assisted living contract. 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	0 485		

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0 485	Continued From page 4 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: During the entrance conference on March 9, 2026, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On page three of the undated (licensee name) Assisted Living Contract, section labeled Primary Services read, "Subject to the Resident's needs, [licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day and (2) snacks are served in the dining area as planned and prepared by [licensee] staff." Resident assisted living contracts lacked an option for residents to opt out of payment for one, two, or three meals residents would not want. On March 9, 2026, at 3:39 p.m., LALD/CNS-A stated the cost for meals and snacks was included the monthly rate charged to residents. LALD/CNS-A further stated LALD/CNS-A was not aware the licensee was required to provide an option for residents to opt out of one, two, or three meals. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided.	0 485		

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0 485	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. 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 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).	0 580		

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0 580	Continued From page 6 The findings include: During the entrance conference on March 9, 2026, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On March 11, 2026, at 12:16 p.m., LALD/CNS-A stated the licensee held staff meetings and discussed resident needs however a process for quality management had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 660 SS=E	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.	0 660		

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0 660	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-C and ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 9, 2026, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on June 15, 2025, and the facility was determined to be a low risk level. ULP-C ULP-C was hired on December 12, 2025, to	0 660		

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0 660	Continued From page 8 provide assisted living services to resident.. On March 10, 2026, at 8:33 a.m., the surveyor observed ULP-C deliver change of shift report to ULP-D. ULP-C's employee record included evidence of ULP-C's chest x-ray dated December 26, 2025. ULP-C's employee record lacked evidence of a TB symptom screening form and evidence of a history of positive TST. ULP-D ULP-D was hired June 18, 2022, to provide direct care services to residents. On March 10, 2026, at 8:43 a.m., the surveyor observed ULP-D administer scheduled medications to R2. ULP-D's employee record included evidence of ULP-D's chest x-ray dated June 11, 2022. ULP-D's employee record lacked evidence of a TB symptom screening form and evidence of a history of positive TST. On March 13, 2026, LALD/CNS-A stated a newly hired employee completed a TB screening form at the licensee's facility and was given a copy to bring to their TB testing at a local clinic. LALD/CNS-A further stated LALD/CNS-A was aware of the requirement for an employee to have a history of positive TB test prior to a chest x-ray however the documentation to support this was not currently in the employee files reviewed. The licensee's Tuberculosis Screening/ Prevention policy dated August 1, 2021, indicated	0 660		

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0 660	Continued From page 9 [licensee] observed the recommended precautions related to TB prevention as identified for the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The policy further indicated employees completed baseline symptom and TB history screening at the time of hire followed by a two-step TST or blood test. The policy also stated, "Employees with a verbal, but undocumented, history of a previous positive TST or BAMT (blood assay for M. tuberculosis) will undergo the same screening process as those without previous positive results." The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 10 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 observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors 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 potential to affect	0 680		

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0 680	Continued From page 11 a large portion or all of the residents). The findings include: During the entrance conference on March 9, 2026, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On March 9, 2026, at 11:28 a.m., during a tour of the facility with LALD/CNS-A, the surveyor did not observe the licensee's EPP or signage that directed staff, residents, or visitors where to locate the EPP. The licensee's undated EPP lacked the following content and/or policies and procedures to address: - an EPP available for all staff, residents, and volunteers to access; - annual review of the EPP; - a missing resident plan that was reviewed quarterly: Missing Resident policy provided was effective August 1, 2021, and lacked documentation of review dates; - the provision of subsistence needs for staff and residents to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting); - a policy and procedure to address the use of volunteers during an emergency; - a policy and procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act for providing care and treatment at alternate care sites under a 1135 waiver; - a communication plan to include: - staff names and contact information - resident physician contact information	0 680		

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	35866	A. BUILDING: _____ B. WING _____	03/13/2026

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0 680	Continued From page 12 - sharing information regarding the licensee's occupancy, needs, and ability to provide assistance - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On March 11, 2026, at 11:02 a.m., LALD/CNS-A stated the licensee's EPP was located in LALD/CNS-A's office in the lower level of the home and acknowledged the above mentioned items were not currently present in the licensee's EPP. LALD/CNS-A further stated tornado drills and missing person drills were completed quarterly however the documentation which supported that was incomplete. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated [licensee] had an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy further indicated the licensee's EPP was prominently posted on each floor of the facility, was reviewed annually, and included conducting a disaster drill 'at least annually'. The licensee's Missing Resident policy dated August 1, 2021, indicated [licensee] immediately investigated any missing resident using an organized approach. The policy further indicated the missing resident procedure was reviewed by the director and CNS at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 13 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. 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, 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	0 775		

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0 775	Continued From page 14 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 March 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 15 (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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 810	Continued From page 16	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 17 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 March 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
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.	01290		

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01290	Continued From page 18 (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 record review and interview, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for one of seven employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living within the facility. 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 of the residents). The findings include: This resulted in an immediate correction order on March 10, 2026. During the entrance conference on March 9, 2026, at 11:08 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the required content of an employee record. ULP-E was hired on April 27, 2020, under the pervious comprehensive home care license and began providing direct care services for the	01290		

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01290	Continued From page 19 residents at the assisted living facility on August 1, 2021. On March 9, 2026, at 4:02 p.m., the LALD/CNS provided NetStudy (online background study platform) which indicated ULP-E's background study for HFID (health facility identification number) 35210 exceeded the COVID-19 study expiration date of December 31, 2022. The licensee's Pay Period staff schedule dated March 1, 2026, through March 14, 2026, indicated ULP-E was scheduled to work seven out of 14 days, from 8:00 p.m. until 8:00 a.m. Furthermore, ULP-E was scheduled to work alone during all scheduled shifts during the pay period except for one-hour scheduled overlap on March 7, 2026. On March 10, 2026, at 2:21 p.m., the surveyor reviewed the staff roster with LALD/CNS-A. LALD/CNS-A stated ULP-E worked independently for the licensee and provided direct care services to residents. LALD/CNS-A further stated LALD/CNS-A was the only employee of the licensee who completed employee background studies and monitored the NetStudy roster for compliance. LALD/CNS-A stated LALD/CNS-A missed ULP-E's expired background study in error. The licensee's Personnel Records policy dated August 1, 2021, indicated each personnel record contained results of completed background study. No further information provided. TIME PERIOD OF CORRECTION: Immediate	01290		

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01370	Continued From page 20	01370		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 21 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of three unlicensed personnel ((ULP)-C and ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 9, 2026, at 11:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of required contents in an employee record. LALD/CNS-A further stated newly hired employees completed knowledge training through EduCare (online training software), skills training the LALD/CNS-A, and demonstrated competency to LALD/CNS-A before working with residents independently. ULP-C ULP-C was hired December 12, 2025, to provide direct care services to residents. On March 10, 2026, at 8:15 a.m., the surveyor	01370		

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01370	Continued From page 22 observed ULP-C complete narcotic medication counting at change of shift with ULP-D. ULP-C's record lacked evidence of training for the following topics: - documentation requirements for all services provided; - maintenance of a clean and safe environment; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - understanding appropriate boundaries between staff and residents and the resident's family. ULP-C's record lacked evidence of demonstrated competency for the following: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing, - care of teeth, gums, and oral prosthetic devices, - care and use of hearing aids, and - dressing and assisting with toileting; and - standby assistance techniques and how to perform them. ULP-D ULP-D was hired June 18, 2022, to provide direct care services to residents. On March 10, 2026, at 8:43 a.m., the surveyor observed ULP-D administer R2's scheduled morning medications. ULP-D's record lacked evidence of training for the following topics: - documentation requirements for all services	01370		

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01370	Continued From page 23 provided; - reports of changes in the resident's condition to the supervisor designated by the facility; and - standby assistance techniques and how to perform them. ULP-D's record lacked evidence of demonstrated competency for the following: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing, - care of teeth, gums, and oral prosthetic devices, - care and use of hearing aids, and - dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On March 12, 2026, at 3:40 p.m., ULP-D stated ULP-D had completed all training issued through EduCare prior to skills training and competency sign-off with LALD/CNS-A. ULP-D further stated ULP-D believed that all training and competencies required were completed before ULP-D had worked independently with residents. On March 13, 2026, at 2:01 p.m., LALD/CNS-A stated orientation training was completed by every employee through EduCare and LALD/CNS-A provided orientation to the specific residents and their needs and competency training at the licensee facility. LALD/CNS-A further stated LALD/CNS-A was unaware there was missing orientation coursework for ULP-C and ULP-D because LALD/CNS-A believed Educare populated the necessary courses to fulfill orientation requirements. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff were prepared to provide safe, effective services	01370		

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01370	Continued From page 24 to all residents through a thorough orientation and education program pertinent to the needs of the residents. The policy further indicated no one was allowed to provide direct care to residents before successfully completing the organization's orientation program. The licensee's Staff Competency policy dated August 1, 2021, indicated training and competency evaluation for all ULPs included the following: documentation requirements for all services provided, reports of changes in resident condition to the supervisor, infection control, maintenance of a clean and safe environment, appropriate and safe techniques in personal hygiene and grooming, prevention of falls, standby assistance techniques and how to perform them, medication, exercise and treatment reminders, basic meal preparation and preparation of modified diets, communication skills to preserve the dignity of the resident and showing respect for the resident and the resident's preferences, awareness of confidentiality and privacy, understanding appropriate boundaries between staff, residents, and the resident's family, handling emergency situations, and awareness of commonly used health technology equipment and assistive devices. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program,	01370		

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01370	Continued From page 25 and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive,	01380		

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	35866	A. BUILDING: _____ B. WING _____	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01380	Continued From page 26 and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of three unlicensed personnel ((ULP)-C and ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 9, 2026, at 11:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of required contents in an employee record. LALD/CNS-A further stated newly hired employees completed knowledge training through EduCare (online training software), skills training the LALD/CNS-A, and demonstrated competency to LALD/CNS-A before working with residents independently. ULP-C ULP-C was hired December 12, 2025, to provide	01380		

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01380	Continued From page 27 direct care services to residents. On March 10, 2026, at 8:15 a.m., the surveyor observed ULP-C complete narcotic medication counting at change of shift with ULP-D. ULP-C's record lacked evidence of training for the following topics: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning. ULP-C's record lacked evidence of demonstrated competency for the following: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning. ULP-D ULP-D was hired June 18, 2022, to provide direct care services to residents. On March 10, 2026, at 8:43 a.m., the surveyor observed ULP-D administer R2's scheduled morning medications. ULP-D's record lacked evidence of training for the following topics: - basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 28 observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning. ULP-D's record lacked evidence of demonstrated competency for the following: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning. On March 12, 2026, at 3:40 p.m., ULP-D stated ULP-D had completed all training issued through EduCare prior to skills training and competency sign-off with LALD/CNS-A. ULP-D further stated ULP-D believed that all training and competencies required were completed before ULP-D had worked independently with residents. On March 13, 2026, at 2:01 p.m., LALD/CNS-A stated orientation training was completed by every employee through EduCare and LALD/CNS-A provided orientation to the specific residents and their needs and competency training at the licensee facility. LALD/CNS-A further stated LALD/CNS-A was unaware there was missing orientation coursework for ULP-C and ULP-D because LALD/CNS-A believed Educare populated the necessary courses to fulfill orientation requirements. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff were prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. The policy further indicated no one was	01380		

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01380	Continued From page 29 allowed to provide direct care to residents before successfully completing the organization's orientation program. The licensee's Staff Competency policy dated August 1, 2021, indicated training and competency evaluation for all ULPs included the following: documentation requirements for all services provided, reports of changes in resident condition to the supervisor, infection control, maintenance of a clean and safe environment, appropriate and safe techniques in personal hygiene and grooming, prevention of falls, standby assistance techniques and how to perform them, medication, exercise and treatment reminders, basic meal preparation and preparation of modified diets, communication skills to preserve the dignity of the resident and showing respect for the resident and the resident's preferences, awareness of confidentiality and privacy, understanding appropriate boundaries between staff, residents, and the resident's family, handling emergency situations, and awareness of commonly used health technology equipment and assistive devices. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training;	01380		

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01380	Continued From page 30 (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=F	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;	01530		

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01530	Continued From page 31 (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 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 observation, interview, and record review, the licensee failed to ensure two of three employees (ULP-B and ULP-C) received the required amount of dementia care training in the required time frame. In addition, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of three employees (unlicensed personnel (ULP)-B and ULP-D). This had the potential to affect all residents and staff.	01530		

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01530	Continued From page 32 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: During the entrance conference on March 9, 2026, at 11:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of required contents in an employee record. LALD/CNS-A further stated newly hired employees completed knowledge training through EduCare (online training software). ULP-B ULP-B was hired on March 9, 2025, to provide direct care services. On March 11, 2026, at 8:07 a.m., the surveyor observed ULP-B administer scheduled medications to R4. ULP-B's record included ULP-B's EduCare transcript which showed evidence that ULP-B had completed four hours of dementia care training as of April 3, 2025. ULP-B's record lacked documentation showing ULP-B had completed the required eight hours of dementia care training within 160 working hours of ULP-B's start date. In addition, ULP-B's record lacked documentation ULP-B had completed the required two hours of initial training on mental	01530		

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01530	Continued From page 33 illness and de-escalation topics which became effective July 1, 2025. ULP-C ULP-C was hired December 12, 2025, to provide direct care services to residents. On March 10, 2026, at 8:15 a.m., the surveyor observed ULP-C complete narcotic medication counting at change of shift with ULP-D. ULP-C's record included ULP-C's EduCare transcript which showed evidence that ULP-C had completed four hours of dementia training within 160 working hours of ULP-C's start date. ULP-C's record lacked documentation showing ULP-C had completed the required eight hours of dementia training within 160 working hours of ULP-B's start date. ULP-D ULP-D was hired June 18, 2022, to provide direct care services to residents. On March 10, 2026, at 8:43 a.m., the surveyor observed ULP-D administer R2's scheduled morning medications. ULP-D's record included ULP-D's EduCare transcript which showed evidence that ULP-D completed 7.75 hours of dementia training within 160 working hours of ULP-D's start date. ULP-D's record lacked documentation showing ULP-D had completed the required eight hours of dementia training within 160 working hours of ULP-D's start date. In addition, ULP-D's record lacked documentation ULP-D had completed the required two hours of initial training on mental	01530		

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01530	Continued From page 34 illness and de-escalation topics which became effective July 1, 2025. On March 13, 2026, at 2:01 p.m., LALD/CNS-A stated LALD/CNS-A was aware of the eight-hour dementia training requirement and had not realized ULP-B and ULP-C had not fulfilled that requirement. LALD/CNS-A further stated LALD/CNS-A was aware of the new mental illness and de-escalation training requirement and ULP-B and ULP-D were not issued the required coursework in error. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees completed at least eight hours of initial dementia education within 160 working hours of the employment start date. The policy did not address the new mental health and de-escalation training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions	01820		

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01820	Continued From page 35 were obtained for one of two residents (R3) who received 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). The findings include: During the entrance conference on March 9, 2026, at 10:54 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility. R3 admitted to the licensee on September 29, 2024. R3's diagnoses included schizophrenia (mental health condition characterized by a mix of hallucinations, delusions, and disorganized thinking and behavior), Generalized Anxiety Disorder, and Autistic Disorder (neurological and developmental condition affecting how a person communicates, interacts, behaves, and learns). R3's Service Plan (Waiver)- Addendum to Contract dated February 3, 2026, indicated R3's services included medication set-up and medication administration. R3's electronic Med (medication) Sheet dated March 2026, indicated R3 had the following PRN (as needed) medications available however, not	01820		

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01820	Continued From page 36 administered: - haloperidol 5 (five) milligrams (mg)- take one tablet by mouth every eight hours as needed for agitation; - lorazepam 1 (one) mg- take one tablet by mouth every six hours as needed; and - zolpidem extended release (ER) 12.5 mg- take one tablet by mouth at bedtime as needed for sleep, up to one time per day. R3's record lacked prescriber orders to include the above listed medications. On March 13, 2026, at 11:55 a.m., LALD/CNS-A sent an email to the surveyor which read, "I do not have the signed order for [R3]'s PRNs because those orders were sent directly to the pharmacy and I have called the provider's office for a copy several times with no avail." On March 13, 2026, at 2:17 p.m., LALD/CNS-A stated LALD/CNS-A was aware of the requirement to include prescription orders in resident files and had attempted to obtain R3's orders, however, did not document those attempts. The licensee's Medication Orders policy dated August 1, 2021, indicated [licensee] maintained a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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01890	Continued From page 37	01890		
01890 SS=F	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 for expired medication for one of four residents (R3). In addition, the licensee failed to ensure medications were maintained bearing a prescription label or label with required content for two medications. 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: During the entrance conference on March 9, 2026, at 10:54 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility. EXPIRED MEDICATIONS On March 10, 2026, at 8:18 a.m., the surveyor	01890		

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01890	Continued From page 38 observed the secure medication with unlicensed personnel (ULP)-D and observed the following expired medications: - R3's lorazepam 1 (one) milligram (mg), quantity 39 tablets, expired November 17, 2025; - R3's haloperidol 5 (five) mg, quantity six tablets, expired October 12, 2025; NON-LABELED MEDICATIONS On March 10, 2026, at 8:18 a.m., the surveyor observed the secure medication with unlicensed personnel (ULP)-D and observed the following expired medications: - partial bottle of Ibuprofen 200 mg lacking a prescription label and expiration date worn off; and - partial bottle of milk of magnesia lacking a prescription label and expired October 2024. On March 10, 2026, at 8:23 a.m., ULP-D stated all staff were responsible for assessing medication expiration dates prior to administration. On March 10, 2026, at 9:56 a.m., LALD/CNS-A stated LALD/CNS-A audited medication cart supplies weekly to observe for expired medications and appropriate labels. LALD/CNS-A further stated, the expired medications found today were missed during audit. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated medications being stored by the licensee would be disposed of by a licensed nurse when they expired. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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01890	Continued From page 39 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

New Bridge Care LLC
10 92nd Avenue NE
Blaine, MN 55434
Anoka County
Parcel:

Phone: 651-398-5825
newbridgecare@gmail.com

License Info

License: HFID 35866
DAN MENSAH
Risk:
License:
Expires on:
CFPM: VACANT
CFPM #: ; Exp:

Inspection Info

Report Number: F1029261070
Inspection Type: Full - Single
Date: 3/11/2026 Time: 10:15:52 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 8
Delivery:

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: 10/23/23-3/11/26: NO MN ISSUED CFPM CERTIFICATE. PIC, DAN MENSAH, MSN, PHN, RN, WITH CLASS COMPLETION CERTIFICATE BUT WITHOUT REQUISITE MN ISSUED CFPM CERTIFICATION. PIC INSTRUCTED TO HAVE ESTABLISHMENT EMPLOY INDIVIDUAL WITH UP-TO-DATE CFPM CERTIFICATE AND TO POST THE CERTIFICATE ONCE RECEIVED.

INFORMATION ON MN CFPM CERTIFICATE ATTAINMENT CAN BE FOUND AT THE FOLLOWING ADDRESSES -

https://www.health.state.mn.us/communities/environment/food/cfpm/index.html

https://mn-mdh.portal.opengov.com/categories/1087/record-types/6498

Comply By: 3/27/2026 Originally Issued On: 3/11/2026

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: UNPASTEURIZED SHELL EGGS ABOVE READY TO EAT (RTE) FOODS IN FRIDGE. PIC INSTRUCTED TO MOVE ITEMS LOWER IN FRIDGE THAN THE RTE ITEMS AND/OR STORE THEM IN A CONTAINER WITH HIGH ENOUGH SIDE WALLS SO AS TO PREVENT ACCIDENTAL CONTAMINATION IN THE CASE OF EGGS BREAKING.
Comply By: 3/11/2026 Originally Issued On: 3/11/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14F *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285F Single-use disposable sanitizer wipes must be used according to US EPA approved manufacturer's label use instructions.
COMMENT: DISPOSABLE WIPES WITHOUT ***FOOD-CONTACT SURFACE*** USAGE INSTRUCTIONS USED IN KITCHEN. PIC INSTRUCTED TO USE DISPOSABLE WIPES WITH ***FOOD-CONTACT SURFACE*** USAGE INSTRUCTIONS, IF DISPOSABLE WIPES ARE SELECTED AS A FOOD-CONTACT SURFACE SANITIZER OPTION.
Comply By: 3/13/2026 Originally Issued On: 3/11/2026

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: NO DATE MARK ON OPENED BAG OF COLESLAW SHREDDED CABBAGE MIX. BAG OPENED YESTERDAY. MANUFACTURER USE-BY DATE OF 3/15. PIC INSTRUCTED TO DATE MARK, 3/10, BUT TO USE BY 3/15, RATHER THAN 3/16, TO NOT EXCEED THE MANUFACTURER'S USE-BY DATE.
Comply By: 3/11/2026 Originally Issued On: 3/11/2026

New Order: 4-100 Equipment Construction Materials
4-101.19 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.
COMMENT: EXPOSED MDF IN AREAS OF CABINETRY. PIC INSTRUCTED TO RESEAL/ENSURE MDF IS NOT EXPOSED TO SPLASH AND SPILLAGE.
Comply By: 3/13/2026 Originally Issued On: 3/11/2026

New Order: 4-400 Equipment Location and Installation
4-402.11A *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
COMMENT: GAPS AT HANDWASHING SINK-WALL JUNCTURE AND KITCHEN COUNTER-BACKSPLASH - WALL JUNCTURES. PIC INSTRUCTED TO SEAL.
Comply By: 3/13/2026 Originally Issued On: 3/11/2026

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: INTERIOR OF SMALLER MICROWAVE WITH ENCRUSTED FOOD DEBRIS. PIC INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 3/11/2026 Originally Issued On: 3/11/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-602.13 *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.
COMMENT: MICROWAVE OVEN DOORS ENCRUSTED WITH RESIDUES. PIC INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 3/11/2026 Originally Issued On: 3/11/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: DRY STORAGE SHELVING WITH SUBSTANTIAL BOWING. PIC INSTRUCTED TO ENSURE SHELVING IS SAFE AND STRONG ENOUGH TO SUPPORT THE WEIGHT PLACED UPON IT.
Comply By: 4/3/2026 Originally Issued On: 3/11/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.19 *Priority Level: Priority 3 CFP#: 53*
MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.
COMMENT: TOILET ROOM DOORS OPEN. CLOSED DURING INSPECTION. PIC INSTRUCTED TO KEEP TOILET ROOM DOORS CLOSED WHEN CLEANING AND/OR OR MAINTENANCE ARE NOT OCCURRING.
Comply By: 3/11/2026 Originally Issued On: 3/11/2026

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION CONDUCTED AS PART OF HRD NURSING SURVEY OF ALF. ESTABLISHMENT DOES NOT SERVE A HIGHLY SUSCEPTIBLE POPULATION. KITCHEN IS RESIDENTIAL IN NATURE AND PROVIDES A SAME-DAY PREPARED FOOD AND BEVERAGE SERVICE. ESTABLISHMENT USES FRIGIDAIRE (FFBD2411NS3A) NSF LISTED DISHWASHER WITH SANITIZE OPTION TO SANITIZE EQUIPMENT AND UTENSILS. IDENTIFIED ISSUES DISCUSSED WITH PIC AND STAFF THROUGHOUT INSPECTION AND COMMUNICATED TO SURVEYOR FOLLOWING THE INSPECTION.

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 F1029261070 from 3/11/2026

DAN MENSAH
PERSON IN CHARGE

Trevor McCliment

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@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

New Bridge Care LLC
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F1029261070
Inspection Type: Full
Date: 3/11/2026
Time: 10:15:52 AM

Equipment Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: FRIDGE at 38 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

New Bridge Care LLC
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F1029261070
Inspection Type: Full
Date: 3/11/2026
Time: 10:15:52 AM

Sanitizing Chemical: Product: QUATERNARY AMMONIUM**; Sanitizing Process:** DISPOSABLE WIPES
Location: Greater Than 400 PPM
Comment:
Violation Issued?: Yes

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 150 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35866016	**Date:** 3/10/2026
Facility Name: New Bridge Care LLC	
Facility Address: 10 92nd Ave NE., Blaine, MN 55434	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The hardwired smoke alarm installed in the upper-level hallway was manufactured in 2012 and was therefore expired. Smoke alarms that exceed 10 years in age from manufacture should be removed and replaced.

3. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: The window crank connected to the egress window in resident room 5 was broken, with the handle disconnected from the assembly. The egress window was not readily openable due to the damage to the crank, and the window required significant effort to open. The window crank should be repaired, and all equipment should be maintained in proper working condition to ensure ready access to the egress window in an emergency.

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

Comments: Dozens of cigarette butts were located on the ground around the facility grounds as well as one cigarette butt located on the wooden patio. These cigarette butts were not properly disposed of. All smoking materials should be properly disposed of in approved receptacles to prevent risk of fire.

☒ **TAG IDENTIFICATION: 0780**

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

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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: The smoke alarms provided throughout the facility were not properly interconnected. The licensee tested smoke alarms by activating alarms and only a small portion successfully sounded during the tests. Smoke alarms should be interconnected such that the activation of any alarm causes all other alarms in the facility to sound.

☒ **TAG IDENTIFICATION: 0810**

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

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The only physical copy of the FSEP at the facility was stored in a locked office room in the basement. The licensee also indicated that the FSEP was available online but could not access documents from the FSEP from the online application in a timely manner during the survey. A copy of the FSEP should be supplied in a location where it is quick and easy to readily access during an emergency. Documents provided during the survey were outdated and not site specific. Later documents were emailed to the surveyor that included some site-specific information but were not maintained to be accurate with references to fire protection equipment that was not present at the facility such as fire alarm pull stations. FSEP plans should be site specific and maintained as accurate for the evacuation, staff and residents' safety.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide fire protection procedures for residents. The FSEP should include procedures for residents for a fire or similar emergency.

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

   Comments: The only documentation of resident training provided was from a training provided on January 31, 2026. No previous training documentation was provided to the surveyor. Residents should be offered training on the FSEP at least once per year.