



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 29, 2026

Licensee

Rest Care Home Services LLC

2421 West 98th Street

Bloomington, MN 55431

RE: Project Number(s) SL37035016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 29, 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 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the 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>

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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.

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,

A handwritten signature in cursive script that reads "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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2026
NAME OF PROVIDER OR SUPPLIER REST CARE HOME SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2421 WEST 98TH STREET BLOOMINGTON, MN 55431		
(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: SL37035016-0 On May 26, 2026, through May 29, 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 three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 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 and interview, the licensee failed to ensure the daily staffing schedule was posted, at the beginning of each work shift, in a central location, accessible to staff, residents, volunteers, and the public, as required, potentially affecting 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	0 470			

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0 470	Continued From page 2 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 lacked a posted daily staffing schedule including: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff members' resident assignments or work location; and - be posted, after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On May 26, 2026, at 11:04 p.m., during a facility tour with clinical nurse supervisor (CNS)-B, a posted staffing schedule was observed on the lower level of the facility dated 2023. The facility lacked a current daily staffing schedule posted in any area of the facility. CNS-B stated they needed to post an updated daily staffing schedule and verbalized he was aware of this requirement. On May 26, 2026, at 1:02 p.m., licensed assisted living director (LALD)-A provided the surveyor with a monthly staff schedule dated January 2024. LALD-A verbalized he would update and post the daily staffing schedule. The licensee's undated Staffing policy indicated, "[Licensee] will maintain sufficient, qualified staff at all times to meet the scheduled and unscheduled needs of all residents receiving	0 470			

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0 470	Continued From page 3 assisted living services, in accordance with Minnesota Statute Chapter 144G and applicable Minnesota Department of Health (MDH) assisted living licensure standards. Staffing decisions at [Licensee] will be based on resident assessments, individualized service plans, resident acuity, and the operational needs of the facility. The facility will never staff below a level that compromises the health, safety, dignity, or well-being of any resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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;	0 480			

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0 480	Continued From page 4 (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, 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.	0 480			

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0 480	Continued From page 5 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 May 26, 2026, 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			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the	0 550			

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0 550	Continued From page 6 individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the licensee's grievance procedure, with the current name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. 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 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: During a facility tour on May 26, 2026, at 11:04 a.m., the surveyor observed the licensee's postings with clinical nurse supervisor (CNS)-B on both upper and lower floors of the facility. The facility lacked a grievance procedure posted with contact information including the name, email and phone number for the contact person for the individual responsible for handling resident grievances. On May 26, 2026, at 11:10 a.m., CNS-B stated, "I know what you are talking about, and I am not sure where that posting went". The surveyor	0 550			

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0 550	Continued From page 7 educated the licensee on the required information for the grievance procedure to be posted in a conspicuous place. CNS-B verbalized he planned to get the grievance procedure posted. The licensee's Notice to Clients on Complaint Process dated October 2015, indicated, "As a client of our home care agency, we want you to know that you have the right to complain about the care or services provided by the agency. We encourage you to let us know if you have any concerns right away. You may call the office at 612-327-0670 at any time. Below we have listed the steps you may take. -The complaint/grievance process will be reviewed with you when you begin receiving services and any time there are changes. -The complaint/grievance process will be left in your client folder in the home -The complaint form will be left in your home chart for your use if you want to write your concerns and send them to us. -At any time that you have a complaint or concern, you may call the office and talk to the Director of Nursing or a nursing supervisor. Many times, the concern can be addressed right away and no further action is needed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an	0 630			

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0 630	Continued From page 8 individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R2 R2 was admitted on July 14, 2024, and had diagnoses including schizoaffective and borderline personality disorder. R2's Service Plan, dated June 25, 2024, indicated R2 received services including housekeeping, meals, laundry, behavior and medication management.	0 630			

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0 630	Continued From page 9 R2's record included an undated document titled, "Staff Monitoring and Interventions for [R2]". R2's record also included an Individual Abuse Prevention Plan, dated May 28, 2026, completed during the survey. Both documents lacked the following required content: -the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3 was admitted on June 1, 2023, and had diagnoses including schizophrenia. R3's Service Plan dated June 1, 2023, indicated R3 received services including housekeeping, meals, laundry, behavior and medication management. R3's undated Individual Abuse Prevention Plan lacked the following required content: -the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On May 27, 2026, at 10:02 a.m., clinical nurse supervisor (CNS)-B stated, via phone, he was not aware of all requirements for the IAPP. CNS-B verbalized the licensee recently started to use a new electronic medical record and did not realize some of the required content was not included. The licensee's undated Reporting Maltreatment of Vulnerable Adults policy, indicated, "3. VULNERABILITY ASSESSMENT. Each	0 630			

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0 630	Continued From page 10 employee of [Licensee] who provides direct services has the following responsibilities: a. Assessment of each resident's vulnerability status upon admission to [Licensee] b. Identification of susceptibility to abuse, including self-abuse and neglect, through assessment of: 1) Physical components, including physical impairments and the ability of the resident and caregiver to provide adequate care. 2) Mental impairments, including mental disabilities, Alzheimer ' s disease, disorientation, and confusion. 3) Emotional status, including passive personality and depression. 4) Physical environment, including safety within the facility. The vulnerability assessment will be documented in the resident's record. When vulnerability is suspected or determined, it will be addressed and highlighted in the care plan and in an individual abuse prevention plan. The plan will be implemented immediately and evaluated a minimum of every 90 days, or more frequently if necessary. Documentation will include the results of implementation of the plan." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660			

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0 660	Continued From page 11 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an annual facility TB risk assessment. 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: On May 26, 2026, at 11:20 a.m., after the entrance conference, the surveyor requested, via email, a copy of the most current TB facility risk assessment. On May 26, 2026, at 1:35 p.m., clinical nurse	0 660			

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NAME OF PROVIDER OR SUPPLIER REST CARE HOME SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2421 WEST 98TH STREET BLOOMINGTON, MN 55431		
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0 660	Continued From page 12 supervisor (CNS)-B provided a TB Facility Risk Assessment dated June 30, 2023, and a completed TB Facility Risk Assessment dated May 2026. When asked by the surveyor, CNS-B stated he completed the May 2026 TB Facility Risk Assessment during the survey on May 26, 2026, when he was unable to locate a more current annual TB Facility Risk Assessment. The licensee lacked a completed annual TB Facility Risk Assessment. The licensee's undated Tuberculosis Screening policy indicated, "6. Follow-up testing b. The agency completes a risk assessment worksheet annually and keeps a copy in agency files." The CDC, "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005" dated December 30, 2005, indicated: The first and most important level of TB controls is the use of administrative measures to reduce the risk for exposure to persons who might have TB disease. Administrative controls consist of the following activities: - assigning responsibility for TB infection control in the setting; - conducting a TB risk assessment of the setting; - developing and instituting a written TB infection-control plan to ensure prompt detection, airborne precautions, and treatment of persons who have suspected or confirmed TB disease; - ensuring the timely availability of recommended laboratory processing, testing, and reporting of results to the ordering physician and infection-control team; - implementing effective work practices for the management of patients with suspected or confirmed TB disease;	0 660			

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0 660	Continued From page 13 - ensuring proper cleaning and sterilization or disinfection of potentially contaminated equipment (usually endoscopes); - training and educating HCWs regarding TB, with specific focus on prevention, transmission, and symptoms; - screening and evaluating HCWs who are at risk for TB disease or who might be exposed to M. tuberculosis (i.e., TB screening program); - applying epidemiologic-based prevention principles, including the use of setting-related infection-control data; - using appropriate signage advising respiratory hygiene and cough etiquette; and - coordinating efforts with the local or state health department. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employees' record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680			

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0 680	Continued From page 15 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 undated emergency disaster preparedness plan lacked evidence of the following required content: -EP plan reviewed and updated annually; -missing resident policy reviewed and updated quarterly; -hazard vulnerability assessment; and -emergency and disaster training to all staff during the initial staff orientation and annually thereafter and emergency and disaster training annually, available to all residents. On May 27, 2026, at 10:52 a.m., clinical nurse supervisor (CNS)-B stated that the licensee purchased a toolkit from Care Providers with the required Appendix Z and emergency preparedness templates but the licensee had not yet been able to fully develop and complete the facility EP. CNS-B verbalized they planned to work on the facility EP documents in the near future. The surveyor requested a copy of the licensee's emergency preparedness policies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775			

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0 775	Continued From page 16 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 26, 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	0 780			

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0 780	Continued From page 17 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, 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	0 780			

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0 780	Continued From page 18 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 May 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 790			

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0 790	Continued From page 19 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 May 26, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 800			

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0 800	Continued From page 20 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 May 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=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,	0 810			

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0 810	Continued From page 21 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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	0 810			

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0 810	Continued From page 22 affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident	0 950			

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0 950	Continued From page 23 must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice advising residents of their right to a designated representative, with the required verbiage, and on a document separate from the contract for two of two residents (R2, R4). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's signed Service Plan, dated June 25, 2024, indicated R2 received services including assistance with housekeeping, laundry, meals, behavior management and medication administration. R4's signed Service Plan, dated September 21, 2020, indicated R4 received services including assistance with housekeeping, laundry, meals, behavior management and medication administration. R2 and R4's Resident Agreements (contracts),	0 950			

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0 950	Continued From page 24 dated June 25, 2024, and August 31, 2021, respectively, lacked evidence R2 and R4 were provided with the following verbatim notice, on a document separate from the contact: "You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On May 28, 2026, at 1:09 p.m., licensed assisted living director (LALD)-A stated he was not aware the licensee's assisted living contract did not include the verbatim notice, and all the licensee's residents had the same contract. LALD-A stated he was not aware of the required verbatim language to be included with the contract indicating the residents' right to designate a representative. On May 29, 2025, at 10:25 a.m., surveyor provided, via email, the required designation of representative verbatim notice to the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	01380			

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01380	Continued From page 25 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, 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 competency evaluations required for unlicensed personnel (ULP) providing assisted living services were completed for one of two employees (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 26, 2026, at 10:26 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated initial training, and competency testing was completed by the	01380			

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NAME OF PROVIDER OR SUPPLIER REST CARE HOME SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2421 WEST 98TH STREET BLOOMINGTON, MN 55431		
(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
01380	Continued From page 26 licensee's nurse. Also, LALD-A verbalized the licensee's orientation and training was completed both in person and utilizing an online training program. On May 26, 2026, from 12:14 p.m. to 12:32 p.m., the surveyor observed unlicensed personnel (ULP-D) assist with medications administration for R2. Two attempts were made to administer medications for R2 but R2 ultimately refused to take the noon medications. ULP-D's employee file lacked documentation of training for the following topics required for ULPs providing Assisted Living services: -observing, reporting, and documenting 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; -safe transfer techniques and ambulation; and -range of motioning and positioning. On May 28, 2026, at 8:25 a.m., the surveyor requested, via email, documentation that had not yet been provided for ULP-D's training. On May 28, 2026, at 12:59 p.m., LALD-A provided, via email, some additional ULP-D records. The records sent also lacked the missing training requirements. On May 28, 2026, at 1:09 p.m., LALD-A stated he thought all the required training was completed by ULP-D, but it appeared some items were still missing.	01380			

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01380	Continued From page 27 The licensee's undated Delegation of Nursing Tasks and Therapy Tasks policy indicated, "[Licensee] will permit unlicensed personnel (aides) who have been selected in accordance with this policy to perform delegated nursing and therapy tasks, so long as applicable Minnesota state laws and regulations are followed and all criteria set forth in this policy are met. No delegated nursing or therapy task shall be performed by unlicensed personnel unless authorized through the process described in this policy." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01470			

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01470	Continued From page 28 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470			

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01470	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing assisted living services to residents for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (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 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: CNS-B CNS-B was hired August 21, 2018, and provided direct nursing care services for the licensee's assisted living residents as of August 1, 2021. On May 26, 2026, at 12:14 p.m., the surveyor observed CNS-B interacting and assisting ULP-D with a medication question during medication administration for R2. CNS-B's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -an overview of the Assisted Living statutes 144G and rules; -handling of emergencies and use of emergency services; -the principles of person-centered planning and	01470			

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01470	Continued From page 30 service delivery and how they apply to direct support services provided by the staff person; -handling of resident complaints, reporting of complaints, where to report complaints, including information on the Office of Health Facility Complaints; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. ULP-D ULP-D was hired September 20, 2020, and provided direct care services for the licensee's assisted living residents as of August 1, 2021. On May 27, 2026, at 8:00 a.m., the surveyor observed ULP-D assist R4 with medication administration. ULP-D's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -an overview of the Assisted Living statutes 144G and rules; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -reporting maltreatment of vulnerable adults or minors; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -handling of resident complaints, reporting of complaints, where to report complaints, including information on the Office of Health Facility Complaints; -the principles of person-centered planning and	01470			

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01470	Continued From page 31 service delivery and how they apply to direct support services provided by the staff person; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On May 28, 2026, at 1:09 p.m., licensed assisted living director (LALD)-A stated, via phone, he was not sure why CNS-B and ULP-D were missing some required initial orientation. LALD-A verbalized they use a combination of videos, in-person, and online training for all employees and were not sure why these orientation courses were missed. The licensee's 1.01 Assisted Living Statute and Rule Overview policy, dated June 2021, indicated staff providing and supervising direct services must complete an orientation to 144G assisted living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500			

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01500	Continued From page 32 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500			

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01500	Continued From page 33 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (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 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: CNS-B CNS-B was hired August 21, 2018, and provided direct nursing care services for the licensee's assisted living residents as of August 1, 2021.	01500			

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01500	Continued From page 34 On May 26, 2026, at 12:14 p.m., the surveyor observed CNS-B interacting and assisting while ULP-D assisted R2 with medication administration. CNS-B's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. ULP-D ULP-D was hired September 20, 2020, and provided direct care services for the licensee's assisted living residents as of August 1, 2021. On May 27, 2026, at 8:00 a.m., the surveyor observed ULP-D assist R4 with medication administration. ULP-D's employee record lacked documentation of eight hours of annual training completed within	01500			

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01500	Continued From page 35 the last 12 months, including the following required topics: -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. On May 28, 2026, at 1:09 p.m., licensed assisted living director (LALD)-A stated, via phone, he was not sure why CNS-B and ULP-D were missing some required annual training. LALD-A verbalized they use a combination of videos, in-person, and online training for all employees and were not sure why these annual training courses were missed being completed. The licensee's undated Annual Required Staff Training policy indicated, "All staff at [Licensee] who perform direct care services will complete at least eight (8) hours of annual training for each 12 months of employment, in accordance with Minnesota Statute § 144G.41, Subd. 2(3) and § 144G.63, Subd. 5." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the	01530			

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01530	Continued From page 36 following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed 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;	01530			

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01530	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed two hours of initial training on mental illness and de-escalation topics for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-B was hired August 21, 2018, and provided direct nursing care services for the licensee's assisted living residents as of August 1, 2021. On May 26, 2026, at 12:14 p.m., the surveyor observed CNS-B interacting and assisting while unlicensed personnel (ULP)-D assisted R2 with medication administration. CNS-B's employee record lacked documentation they completed the required 2 hours of initial training on mental illness and de-escalation topics within 120 hours of start date as required for supervisors, effective July 1, 2025. On May 28, 2026, at 1:09 p.m., licensed assisted living director (LALD)-A stated, via phone, he was not sure why CNS-B was missing the training.	01530			

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01530	Continued From page 38 On May 28, 2026, at 1:37 p.m., CNS-B stated he could not find his mental illness training documentation. CNS-B verbalized the transcripts provided including training he completed, and the mental illness and de-escalation training must have been missed. The licensee's undated Dementia Care Training policy, indicated, "The purpose of this policy is to ensure that all staff at [Licensee] who provide care to residents with Alzheimer's disease and other dementias are properly trained in dementia care and the person-centered care approach, in full compliance with Minnesota Statute § 144G.83. This policy establishes the minimum training requirements, staffing expectations, documentation obligations, and emergency procedures that apply to all direct care staff and supervisory personnel at this facility." The licensee's undated Mental Illness and De-escalation Training policy, indicated, "TRAINING REQUIREMENTS The following training requirements apply to all staff at [Licensee]: -Supervisors: -Initial Training: 2 hours within 120 hours of employment -Annual Training: 1 hour -Direct Care Staff: -Initial Training: 2 hours within 160 hours of employment -Annual Training: 1 hour -Non-Direct Care Staff: -Initial Training: 2 hours within 160 hours of employment -Annual Training: 1 hour -Assisted Living with Dementia Care Staff: -Initial Training: 2 hours within 80 working hours of employment	01530			

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01530	Continued From page 39 -Annual Training: 1 hour." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff document the reason why medication administration was not completed as prescribed, for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2026
NAME OF PROVIDER OR SUPPLIER REST CARE HOME SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2421 WEST 98TH STREET BLOOMINGTON, MN 55431		
(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
01760	Continued From page 40 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 26, 2026, at 10:26 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication management services which included weekly medication setup into medi-set containers. CNS-B further stated the licensee used bubble packed medications provided from the pharmacy. R2's Service Plan, dated June 25, 2024, indicated R2 received services including housekeeping, meals, laundry, behavior and medication management. On May 26, 2026, at 12:14 p.m., the surveyor observed ULP-D assist R2 with medication administration. Two attempts were made to administer medications for R2 but R2 eventually refused to take her noon medications. R2's signed provider orders dated January 9, 2026, indicated orders including but not limited to the following: -Ceftin (an antibiotic) 500 mg, one tablet by mouth, every 12 hours for seven doses (start date of November 19, 2025); -clonazepam (to treat panic or bipolar disorders) .5 mg, one tablet by mouth, three times daily; -dexamethasone (a corticosteroid) 4 mg, one tablet by mouth twice daily, for three days (start date of November 19, 2025); -levofloxacin (for bacterial infection) 500 mg, one tablet once daily for seven days (start date of November 19, 2025); and -sulfamethoxazole and trimethoprim (for infection)	01760			

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01760	Continued From page 41 800-160 mg, one tablet every Monday, Wednesday, Friday morning. R2's medication administration record (MAR) dated May 1, 2026, to May 27, 2026, indicated R2 was administered the following medications in May 2026, contrary to the provider orders above: -Ceftin 500 mg, prescribed November 19, 2025, to end after 7 doses; documented as administered once daily May 1-3, 6-23, and 25-26, -dexamethasone 4 mg, prescribed November 19, 2025, to end after 3 days; documented as administered daily May 1-3, 6-23, and 25-26, -levofloxacin 500 mg, prescribed November 19, 2025, to end after 7 days; documented as administered daily May 1-3, 6-23, and 25-26, -sulfamethoxazole and trimethoprim 800-160 mg, prescribed to be administered every Monday, Wednesday and Friday morning; documented as administered daily May 1-3, 6-23, and 25-26, and -clonazepam 0.5 mg prescribed to be administered three times daily; documented as 1 mg administered May 27, 2026, at 8:00 a.m. On May 28, 2026, at 8:56 a.m., CNS-B stated, via phone, he was still getting familiar with the licensee's electronic medical record (EMR), and it appeared the medication end dates for R2 were not entered correctly into the EMR. CNS-B stated he did not believe these medications were given to the residents daily, as documented, because he sets up the medications weekly into medi-set containers weekly for the R2 and all the residents. CNS-B was not sure why the staff had not notified him and continued to document these medications as administered daily. CNS-B stated he needed to become more accurate with the EMR being used. CNS-B further stated he updated R2's MAR with an end date of May 26,	01760			

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01760	Continued From page 42 2026, and May 27, 2026, during the survey, for R2's medication orders that were no longer active. The licensee's undated Documentation of Medication Administration Policy indicated, "PURPOSE 1. To ensure that every medication administration, reminder, or assistance event at [Licensee] is accurately and completely documented in the resident's Medication Administration Record (MAR) or other facility-designated form or electronic system at the time it occurs. 2. To create a clear, reliable record of each resident's medication administration history that supports continuity of care, nurse oversight, and compliance with Minnesota Statute § 144G.71, Subd. 8 and Minnesota Department of Health assisted living licensure standards. 3. To establish a consistent procedure for documenting and reporting any circumstance in which a medication is not administered as prescribed." The licensee's undated Medication Prescriptions and Refills Policy indicated, "RN RESPONSIBILITY FOR CURRENT PRESCRIPTIONS - Minn. Stat. § 144G.71, Subd. 11., The RN at [Licensee] is responsible for ensuring that current, authorized prescriber prescriptions for all medications, including over-the-counter medications and dietary supplements, are: a. Addressed in the resident's care plan, service plan, and Medication Administration Record (MAR). b. Communicated to all appropriate facility staff responsible for administering or monitoring the resident's medications. c. Kept current and renewed as required under	01760			

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01760	Continued From page 43 this policy." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup by the registered nurse (RN) included all the required content for two of two residents (R2, R4). 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: On May 26, 2026, at 10:26 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication	01770			

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01770	Continued From page 44 management services which included weekly medication setup by the RN for all the licensee's residents into weekly medication set up containers. Also, CNS-B stated the licensee used bubble packed medications provided from the pharmacy. R2 R2 was admitted on July 14, 2024, and had diagnoses including schizoaffective and borderline personality disorder. R2's Service Plan, dated June 25, 2024, indicated R2 received services including housekeeping, meals, laundry, behavior and medication management. R2's assessment dated March 12, 2026, indicated on page four, Medication Management, "Licensed nurse responsible for monitoring medication supplies and reordering as needed, specify: Yes - Specify: RN monitor and setup med weekly." On May 26, 2026, from 12:14 p.m. to 12:32 p.m., the surveyor observed unlicensed personnel (ULP)-D assist R2 with medication administration. R2's medications had been set up in a mediset pill container. Two attempts were made to administer medications for R2 but R2 refused to take her noon medications. On May 27, 2026, at 12:26 p.m., CNS-B provided, via email, a document titled, "RN Weekly Medication Review Progress Notes," dated March 7, 2026, to May 22, 2026. The progress note entries addressed review of R2's medication administration documentation including medication refusals, "as needed" medication administration and follow-up, and monitoring for	01770			

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01770	Continued From page 45 side effects and medication tolerance. The progress notes lacked information related to medication set-up. R2's record lacked documentation of medication setup to include the following: - name of medication; - quantity of dose; - times to be administered; and - route of administration. R4 R4 was admitted on November 20, 2020, and had diagnoses including schizophrenia with acute exacerbation and obsessive-compulsive disorder. R4's signed Service Plan, dated September 21, 2020, indicated R4 received services including assistance with housekeeping, laundry, meals, behavior management and medication administration. R4's assessment dated March 12, 2026, indicated on page three, Medication Administration, "Needs help taking medications (Med admin): Staff set up and administer med." On May 27, 2026, at 8:00 a.m., the surveyor observed ULP-D assist R4 with medication administration. ULP-D stated the nurse set up R4's medications weekly. R4's record lacked documentation of medication setup to include the following: - name of medication; - quantity of dose; - times to be administered; - route of administration; and - name of person completing medication setup.	01770			

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01770	Continued From page 46 On May 28, 2026, at 1:37 p.m., CNS-B stated, via phone, he was responsible for medication setup and was not aware of the required documentation for medication setup. CNS-B verbalized he completed a weekly medication review progress note but was not aware of the required medication information to be included. The licensee's undated Medication Set-Up policy indicated, "2. MEDICATION ADMINISTRATION RECORD A Medication Administration Record (MAR) or other approved medication documentation method will be used at [Licensee] to set up and document medications at every medication set-up. The MAR is the authoritative record of what medications a resident is to receive and must be current, accurate, and consistent with the prescriber's orders at all times." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01820 SS=F	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 there were current written or electronically recorded prescriptions as defined in section 151.01,	01820			

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01820	Continued From page 47 subdivision 16 a, for all prescribed medications that the assisted living facility was managing for two of two residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on July 14, 2024, and had diagnoses including schizoaffective and borderline personality disorder (mental health disorders). R2's Service Plan, dated June 25, 2024, indicated R2 received services including housekeeping, meals, laundry, behavior and medication management. R2's medication administration record (MAR) for May 2026, indicated R2 was scheduled to take the following medications: -ammonium lactate (for dry skin) 12 percent (%) 5-10 gram (g), to foot skin, twice daily; -aspirin (for pain) 81 milligrams (mg) one tablet once daily; -Austedo (deutetrabenazine, for involuntary movements) 12 mg, one tablet by mouth, twice daily; -buspirone (for anxiety) 30, one tablet by mouth, twice daily; -Ceftin (an antibiotic for bacterial infection) 500	01820			

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01820	Continued From page 48 mg, one tablet, by mouth, every 12 hours for seven days; -clonazepam (for panic disorders) 1 mg, one tablet by mouth, three times daily; -clozapine (an antipsychotic) 50 mg, one tablet by mouth, twice daily; -dexamethasone (decrease inflammation) 0.5/5 milliliters (ml), scheduled according to chemotherapy treatments; -dextromethorphan (a cough suppressant) 10/100 mg, 10 ml by mouth, every four hours; -docusate Sodium (for constipation) 100 mg, two capsules by mouth, once daily; -fluticasone (to decrease respiratory inflammation) 220 micrograms (mcg), inhale one puff twice daily; -gabapentin (for nerve pain) 800 mg, one tablet by mouth, three times daily; -Lasix (to decrease swelling) 20 mg, one tablet by mouth, twice daily; -levofloxacin (for bacterial infections) 500 mg, one tablet by mouth, once daily for seven days; -Pepcid (to treat heartburn) 20 mg, one tablet by mouth, twice daily -polyethylene glycol (for constipation) 17 g, by mouth daily -prednisone (to decrease inflammation) 20 mg, by mouth per titration schedule; -sulfamethoxazole and trimethoprim (for urinary tract infections) 800-160 mg, one tablet by mouth, every Monday, Wednesday, Friday morning; and -haloperidol (an antipsychotic) 5 mg, one tablet by mouth, daily in afternoon. R2's record included signed provider orders, dated January 9, 2026, but lacked a provider order with signature for the following medication from the list above: -clonazepam 1 mg, one tablet three times daily.	01820			

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01820	Continued From page 49 R4 R4 was admitted on November 20, 2020, and had diagnoses including schizophrenia with acute exacerbation and obsessive-compulsive disorder. R4's signed Service Plan, dated September 21, 2020, indicated R4 received services including assistance with housekeeping, laundry, meals, behavior management and medication administration. R4's MAR for May 2026, indicated R4 was scheduled to take the following medications: -fluticasone 100-50, inhale one puff twice daily; -lisinopril (for hypertension) 20 mg, one tablet by mouth daily; -montelukast (for asthma) 10 mg, one tablet by mouth, daily; -vitamin D3 (a supplement) 25 mcg, one capsule by mouth daily; -clozapine 200 mg, one tablet by mouth once daily at bedtime; -albuterol sulfate (for asthma) 90 mcg 8.5 g, inhale one puff twice daily, as needed (PRN); -nicotine polacrilex (for smoking cessation), chew one piece of gum daily PRN; -Tylenol (acetaminophen, for pain)) 1 tablet daily PRN; -Ventolin HFA 90 mcg, inhale two puffs, every four hours as needed. R4's record included an After Visit Summary (AVS) dated February 17, 2026, but lacked a provider order with signature for the following medications from the list above: -fluticasone 100-50, inhale one puff twice daily; -lisinopril 20 mg, one tablet by mouth, daily; -montelukast 10 mg, one tablet by mouth, daily; -vitamin D3 25 mcg, one capsule by mouth, daily; -clozapine 200 mg, one tablet by mouth, once	01820			

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01820	Continued From page 50 daily at bedtime; and -clozapine 50 mg, one tablet by mouth, once daily at bedtime (total of 250 mg); and -albuterol sulfate 90 mcg, inhale two puffs by mouth, every four hours as needed. On May 28, 2026, at 1:37 p.m., clinical nurse supervisor (CNS)-B stated, via phone, he used the AVS provider documentation when implementing new orders. CNS-B stated R4 would not let the licensee attend his medical appointments so all they received were the AVS documents with provider changes. Also, CNS-B verbalized he could not find a signed current order for R2's clonazepam. CNS-B was not aware of the requirement for all orders to be either manually or electronically signed by the provider. Education provided. On May 28, 2026, at 12:32 p.m., the surveyor provided, via email, statutory regulatory language and requirements for prescriptions. The licensee's undated Medication Prescriptions and Refills policy indicated, "When [Licensee] is responsible for managing a resident's medications, this responsibility will be documented in the resident's individualized medication management plan. The facility RN will develop and maintain written procedures for requesting and receiving medication prescriptions. A current, written prescriber's prescription must be obtained for any medication, including over-the-counter medications and dietary supplements, whenever facility staff are responsible for setting up the medication, administering the medication, or providing other medication management services for a resident. No medication will be administered by facility staff without a current, valid prescription on file."	01820			

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01820	Continued From page 51 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required posting at the main entry way of the facility, including statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 26, 2026, at 11:04 a.m., the surveyor observed the licensee's postings in all areas of	03090			

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03090	Continued From page 52 the facility within the presence of clinical nurse supervisor (CNS)-B. The licensee had a sign on the outside of the garage indicating there was 24-hour video surveillance. CNS-B stated he was aware of the required electronic monitoring verbiage required to be posted but was not sure where the posting went. The licensee lacked an electronic monitoring notice posted with the required statutory language. On May 28, 2026, at 12:31 p.m., the surveyor provided, via email, statutory language for the electronic monitoring posting notification to the licensee. The licensee's Electronic Monitoring policy dated January 1, 2020, indicated., "Effective January 1, 2020, [Licensee] complies with the Minnesota Electronic Monitoring Law under Minnesota Statute § 144.6502. Residents or their representatives may conduct electronic monitoring in the resident ' s room or private living unit consistent with the consent, notification, and other requirements set forth in Minnesota law. [Licensee] will not retaliate against any resident, resident representative, or other person who uses or requests electronic monitoring in accordance with this policy and applicable law." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

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Establishment Info

REST CARE HOME SERVICES LLC
2421 WEST 98TH STREET
Bloomington, MN 55431
Parcel:
Phone:

License Info

License: HFID 37035
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1039261146
Inspection Type: Full - Single
Date: 5/26/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 4
Delivery: Emailed

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 CFPM IS EMPLOYED. STAFF COMPLETED SERVSAFE IN 2022. GUIDANCE ON TOPIC SENT WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 5/26/2026 Originally Issued On: 5/26/2026

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 Priority Level: Priority 1 CFP#: 22

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: DAIRY MILK IN COOLER MEASURES 45 DEGREES F. COMPLY WITH ABOVE RULE. COOLER THERMOSTAT ADJUSTED.

Comply By: 5/26/2026 Originally Issued On: 5/26/2026

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: LOLLIPOP-STYLE MAX-HOLD WATERPROOF PROBE THERMOMETER DOESN'T NOT FUNCTION. BRING TO FUNCTION OR REPLACE.

Comply By: 6/5/2026 Originally Issued On: 5/26/2026

New Order: 4-600 Cleaning Equipment and Utensils

4-601.11C Priority Level: Priority 3 CFP#: 49

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

COMMENT: SOILS ACCUMULATED ON CABINET FACES AND ATOP COOLER. CLEAN AND MAINTAIN CLEAN.

Comply By: 6/5/2026 Originally Issued On: 5/26/2026

New Order: 5-200A Plumbing: approved materials/design

5-201.11B Priority Level: Priority 3 CFP#: 51

MN Rule 4626.1040B Maintain the plumbing system in good repair.

COMMENT: 2-COMPARTMENT SINK FAUCET IS LOOSE IN MOUNTING. TIGHTEN FAUCET.

Comply By: 6/2/2026 Originally Issued On: 5/26/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.14A *Priority Level: Priority 3 CFP#: 10*

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: NO HANDWASHING REMINDER SIGN IS POSTED AT 2-COMPARTMENT SINK IN KITCHEN. ADD SIGN AT COMPARTMENT DESIGNATED FOR HANDWASHING.

Comply By: 5/26/2026 Originally Issued On: 5/26/2026

Food & Beverage General Comment

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Dede Hinnendael.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and laminate countertops, laminate wood floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair.

A 2-compartment sink is present in kitchen. 1 compartment must be designated for handwashing only.

A chest freezer is in-use in basement.

A residential dishwashing machine is present in the kitchen. By thermo test strip results emailed by person-in-charge, the dishwashing machine rinse temperature at utensil surface exceeds 160 degrees F.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, cleaning and sanitizing, all orders on this report.

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 F1039261146 from 5/26/2026



Sambe Varney
person-in-charge

Aron Goodner,
Public Health Sanitarian
651-201-4910
aron.goodner@state.mn.us



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

REST CARE HOME SERVICES LLC
Bloomington
County/Group:

Inspection Info

Report Number: F1039261146
Inspection Type: Full
Date: 5/26/2026
Time: 11:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Greater Than 160 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37035016-0	Date: May 26, 2026
Facility Name: REST CARE HOME SERVICES LLC	
Facility Address: 2421 WEST 98TH STREET BLOOMINGTON MN 55431	

☒ **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. 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: Facility smoking area had several cigarette butts lying on the ground. The surrounding area had dried vegetation which increased risk of fire.

3. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

Comments: An open top metal can was being used to dispose of cigarette butts. The can was also being used as a trash receptacle for other combustible material.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The battery smoke alarm in resident bedroom #1 didn't work when tested. The facility didn't have another battery to replace the existing one resulting in operational alarm in the resident room.

Resident bedrooms #2 and #4 were missing smoke alarms, the facility wasn't sure where the alarms were.

2. Smoke alarms 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 facility used multiple brands of smoke alarms in different areas of the house, which resulted in the alarms not being interconnected when tested.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The facility fire extinguishers had not received their annual service during the past year.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments: The facility rear wooden deck had a loose railing, the railing post closet to the ground had begun to separate from the stairs. The deck had several areas of chipping or peeled paint and was not being maintained.

In resident bedroom #1, the ceiling fan housing had slipped down and exposed the fans wiring. The exposed wiring presents a hazard and is not being maintained with manufacture instructions.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor observed the evacuation plans lacked accurate identification of resident room numbers. Exit plan diagrams must be correctly labeled to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

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

Comments: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The facility used an electronic care plan website for standard resident evacuation procedures. The FSEP didn't include standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

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

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

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

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