Electronically Delivered

June 11, 2026

Licensee
Morning Glory Homes Incorporated
4328 Williston Road
Minnetonka, MN 55345

RE: Project Number(s) SL31881016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 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:

0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $1,000.00
0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $1,000.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,500.00**. 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

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.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Morning Glory Homes Incorporated. Please contact Casey DeVries at 651-201-5917 on or before Tuesday, June 16, 2026 to schedule the conference call.

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31881	A. BUILDING: _____ B. WING _____	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY HOMES INCORPORAT	4328 WILLISTON ROAD MINNETONKA, MN 55345

(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: SL31881016-0 On April 27, 2026, through April 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 five residents; five 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.	
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to employ an assisted living director who was licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS) and affiliated as the director of record with the board. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The Minnesota BELTSS results page for the licensee indicated that agent (A)-A was the prior licensed assisted living director (LALD) and director of record for the facility from August 1, 2020, to October 22, 2025. No other LALD was listed as director of record. A-A's BELTSS results page contained a Stipulation and Order document listed under public documents which indicated a disciplinary revocation of A-A's ALD licensure. The document was signed by A-A on October 22, 2025.	0 110		

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0 110	Continued From page 2 On April 27, 2026, at 10:28 a.m., A-A stated they were no longer the LALD for the facility, and they had been in the process of bringing on a new LALD but had so far been unable to do so. The licensee's 4.01 Assisted Living Director policy dated August 1, 2021, indicated the licensee was required to have an Assisted Living Director licensed or permitted by BELTSS. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 110		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The	0 340		

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0 340	Continued From page 3 commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient documentation of actions taken to comply with the correction orders from a survey completed June 11, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents of the licensee. 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 July 8, 2024, the licensee (health facility identification number (HFID) 31881) received results from the previous survey concluded on June 11, 2024. The longest time period for correction (the time frame by which the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was September 9, 2024. The licensee's correction orders issued following the June 2024 survey included the following 19 tags: 0470, 0480, 0580, 0650, 0660, 0680, 0780,	0 340		

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0 340	Continued From page 4 0790, 0800, 0810, 0950, 1330, 1470, 1500, 1530, 1620, 1650, 1910, and 3090. On April 27, 2026, at 1:15 p.m., agent (A)-A stated to the engineering surveyor they did not have any of the documentation related to the fire safety and evacuation plan, training, drills, or resident levels with them or on site. A-A stated their son had it at their other facility but it was incomplete. On April 27, 2026, at 4:31 p.m., via email, A-A provided the engineering surveyor a written plan of correction (POC) and represented it was for the licensee's previous survey completed on June 11, 2024, by indicating on the document it was for HFID 31881 and for "williston 2024", which was the street name for the licensee's facility address. A-A wrote, "My son brought over the binder with all the emergency plans, but it is not complete. See attached correction plan from last survey." On April 28, 2026, at 2:37 p.m., via email, A-A again provided the same POC to the nursing surveyor. The first page of the 15 page document contained a correction order summary and listed information for the following 16 tag identifiers: 0120 for incorrect marketing on the website (not issued following the survey), 0480 for food handling, 0490 for daily activities (not issued following the survey), 0510 for hand hygiene (not issued following the survey), 0630 for individual abuse prevention plans (not issued following the survey), 0660 for tuberculosis documentation, 0680 for disaster planning and exit diagrams, 0810 for fire prevention, 0820 for fire egress/window too small (not issued following the survey), 1060 for emergency relocation (not issued following the survey), 1090 [sic] for background studies (not issued following the	0 340		

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0 340	Continued From page 5 survey), 1530 for dementia training, 1620 for assessments, 1760 for documentation of medication administration (not issued following the survey), 1880 for storage of medications (not issued following the survey), and 2310 for bed rail safety (not issued following the survey). The POC represented to the surveyor did not address the following tags which were issued upon completion of the June 2024 survey: 0470 for development and implementation of a staffing plan, 0580 for quality management, 0650 for staff records, 0780 for interconnected smoke alarms, 0790 for annual maintenance on fire extinguishers and adequately rated portable fire extinguishers, 0800 for maintenance of the physical environment in a continuous state of good repair and operation, 0950 for designation of a representative, 1330 for unlicensed personnel, 1470 for content of required orientation, 1500 for required annual training, 1650 for service plans, 1910 for disposition of medications, and 3090 for notice to visitors. The surveyor observed Minnesota Department of Health records for a survey completed on July 5, 2024, for another facility under the same ownership umbrella as the licensee (HFID 29504). The correction orders issued following that facility's survey included the same list of tag identifiers the licensee represented on their POC for HFID 31881. During the survey initiated on April 27, 2026, and exited on April 29, 2026, areas of deficient practice related to the following tags and correction orders were re-issued: - 0660; - 0680; - 0780;	0 340		

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0 340	Continued From page 6 - 0790; - 0800; - 0810; - 1500; - 1530; and - 1620. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and	0 480		

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

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0 480	Continued From page 8 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 April 28, 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		
0 630 SS=D	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 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	0 630		

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0 630	Continued From page 9 the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on December 14, 2024, to receive assisted living services. R2's diagnoses included end stage cardiac disease. R2's service plan dated December 14, 2024, indicated R2 received assisted living services to include safety checks, skin care, behavior management, blood glucose monitoring, dressing, linen change, medication administration, oral cares, bathing assistance and vital signs. R2's IAPP dated April 20, 2026, lacked an assessment on whether R2 was susceptible to abuse from others. On April 29, 2026, at 2:11 p.m., clinical nurse supervisor (CNS)-B stated the missing information was an oversite on their behalf and R2 was not at risk for abuse from others. CNS-B stated they would correct the issue on R2's assessments. The licensee's 6.05 Individualized Abuse	0 630		

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0 630	Continued From page 10 Prevention Plan policy dated August 1, 2021, indicated all residents would have an IAPP addressing the person's susceptibility to abuse, the person's risk of abusing other vulnerable adults, and specific measures would be taken to minimize the risk of abuse to that person and other vulnerable adults. 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 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers	0 660		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 11 for Disease Control and Prevention (CDC). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 facility TB risk assessment dated June 13, 2024, indicated the facility was at medium risk. On April 28, 2026, clinical nurse supervisor (CNS)-B verified that the facility TB risk assessment on file was the most current assessment completed. CNS-B stated they were not aware that it was an annual requirement. The licensee's 8.01 Infection Control Policy dated July 28, 2021, indicated their infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "each provider licensed by MDH is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee	0 660		

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0 660	Continued From page 12 and in determining the frequency of screening." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies 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	0 680		

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0 680	Continued From page 13 licensee failed to have a written emergency disaster preparedness plan with all 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 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 the survey, the licensee did not have a complete or usable emergency plan available for review. On April 27, 2026, at 1:26 p.m., agent (A)-A stated they were responsible for the development of the licensee's EPP. A-A stated they had bought the EPP template from a company, and that it was not currently available for review. The licensee's 9.01 Emergency Preparedness Plan -Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would have in place an effective and compliant EPP and the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further information was provided.	0 680		

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0 680	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 27,2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 15 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more	0 780		

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0 780	Continued From page 16 than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 27,2026, 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 17 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 April 27,2026, 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 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 800		

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0 800	Continued From page 18 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 April 27,2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 19 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 27,2026, for the specific violations related the physical	0 810		

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0 810	Continued From page 20 environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training 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	01500		

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01500	Continued From page 21 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 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 interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment for one of three employees (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 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	01500		

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01500	Continued From page 22 situation has occurred only occasionally). The findings include: ULP-D was hired January 4, 2024, to provide assisted living services. ULP-D's employee record lacked documentation of the following required annual training topics: - Assisted Living Bill of Rights; 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. On April 28, 2026, at 11:53 p.m., agent (A)-A stated, "full disclosure, if it is not on ULP-D's transcript, it was not completed". A-A stated the training had been assigned but they were not aware the training was not completed. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated the following: "The following training elements MUST be included every 12 months to all staff who performs direct care services: 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	01500		

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01500	Continued From page 23 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 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of	01530		

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01530	Continued From page 24 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all staff received eight hours of initial dementia care training within 160 working hours of employment for direct care staff as required for one of three employees (unlicensed personnel (ULP)-D). Additionally, the licensee failed to ensure direct care staff completed two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for three of three employees (clinical nurse supervisor	01530		

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01530	Continued From page 25 (CNS)-B, ULP-C, 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 March 1, 2013, to provide assisted living services and clinical oversite. CNS-B's employee record lacked documentation of the required initial two hours of mental illness and de-escalation training within 120 hours of hire. ULP-C ULP-C was hired May 5, 2025, to provide assisted living services. On April 27, 2026, from 7:35 a.m. to 8:38 a.m., the surveyor observed ULP-C provide assisted living services to residents within the facility. ULP-C's employee record lacked documentation of the required initial two hours of mental illness and de-escalation training within 160 hours of hire. ULP-D ULP-D was hired January 4, 2024, to provide assisted living services.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31881	A. BUILDING: _____ B. WING _____	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY HOMES INCORPORAT	4328 WILLISTON ROAD MINNETONKA, MN 55345

(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
01530	Continued From page 26 On April 27, 2026, from 7:35 a.m. to 8:38 a.m., the surveyor observed ULP-D provide assisted living services to residents within the facility. ULP-D's employee record lacked documentation of the required initial eight hours of dementia care training and two hours of mental illness and de-escalation training within 160 hours of hire. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. Supervisors of direct care staff will complete eight hours of initial training within 120 hours of the start date and direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. The licensee's policies did not address the new statutory requirement to provide mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident	01620		

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01620	Continued From page 27 executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

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01620	Continued From page 28 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 December 14, 2024, to receive assisted living services. R2's diagnoses included end stage cardiac disease. R2's service plan dated December 14, 2024, indicated R2 received assisted living services to include safety checks, skin care, behavior management, blood glucose monitoring, dressing, linen change, medication administration, oral cares, bathing assistance, and vital signs. R2's record indicated their most recent 90-day assessment occurred on April 20, 2026, with their	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 29 prior 90-day assessment occurring on January 7, 2026. This indicated 103 days had passed between assessments. R2's next assessment was dated September 23, 2025, which indicated 106 days had passed between assessments. R3 R3 was admitted on September 15, 2016, to receive assisted living services. R3's diagnoses included paranoid schizophrenia. R3's service plan dated July 24, 2024, indicated R3 received assisted living services to include activity assistance, grooming, housekeeping, laundry, linen change, repositioning, catheter care, bathing assistance, dressing, transfer assistance, medication administration, and toileting. R3's record indicated their most recent 90-day assessment occurred on April 20, 2026, with their prior 90-day assessment occurring on January 7, 2026. This indicated 103 days had passed between assessments. R3's next assessment was dated September 23, 2025, which indicated 106 days had passed between assessments On April 28, 2026, at 10:38 a.m., clinical nurse supervisor (CNS)-B stated they had gotten a little behind on resident assessments but had been working on getting caught up. Additionally, CNS-B stated they had been under the assumption that assessments needed to be completed on day 90 after the last assessment and was not aware assessments could not exceed 90 days and could be done prior. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated	01620		

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01620	Continued From page 30 ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	01650		

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01650	Continued From page 31 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of four residents (R2 and 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 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 December 14, 2024, to receive assisted living services. R2's diagnoses included end stage cardiac disease. R2's service plan dated December 14, 2024, indicated R2 received assisted living services to include safety checks, skin care, behavior management, blood glucose monitoring, dressing, linen change, medication administration, oral cares, bathing assistance, and vital signs. R3 R3 was admitted on September 15, 2016, to	01650		

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01650	Continued From page 32 receive assisted living services. R3's diagnoses included paranoid schizophrenia. R3's service plan dated July 24, 2024, indicated R3 received assisted living services to include activity assistance, grooming, housekeeping, laundry, linen change, repositioning, catheter care, bathing assistance, dressing, transfer assistance, medication administration, and toileting. R2 and R3's service plans were included in and developed in conjunction with the signing of an assisted living contract. This service plan lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan that includes the action to be taken if the scheduled service cannot be provided, information and a method to contact the facility, the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On April 28, 2026, at 9:02 a.m., clinical nurse supervisor (CNS)-B stated that whenever there was a change to services or an update to the service plan, they had been in the practice of printing out an entire new contract to have the resident sign and were unaware there was an	01650		

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01650	Continued From page 33 abbreviated version that contained all required contents available in their online medical record charting system to be used in place of the full contract. Additionally, CNS-B stated they were unaware the contract lacked the required content. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated service plans would include: -the identification of staff or categories of staff who will be providing services; -a schedule and method for the next planned assessment or monitoring; -a schedule and method for the next planned monitoring staff providing the services; and -a contingency plan that includes actions [licensee] will take if a service cannot be provided, information how the resident can contact [licensee], names and contact information the resident wishes to have contacted in case of an emergency, identification and contact information of who the resident has authorized to sign in care of an emergency, and how the facility will support documented resident health care directive decisions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents in 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: On April 27, 2026, at 12:10 p.m., the surveyor observed the licensee's medication refrigerator located in the main kitchen and dining area of the facility. The refrigerator had a hasp-style lock mounted on the side which required a pad lock in order to be secured. The hasp lock lacked a pad lock and was unsecure and able to be accessed without assistance from staff. The storage refrigerator was in active use and being utilized to store temperature sensitive medications for residents within the facility. On April 28, 2026, at 3:01 p.m., in the presence of staff, the surveyor observed the medication cabinet was unlocked and demonstrated to staff they were able to access the medication cabinet without assistance from staff.	01880		

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01880	Continued From page 35 On April 29, 2026, at 2:13 p.m., clinical nurse supervisor (CNS)-B stated they would retrain staff to ensure that the cabinet was locked when not in use. The licensee's 7 .11 Medication Storage policy dated July 30, 2021, indicated when medications are managed and stored by the licensee, medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890		

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01890	Continued From page 36 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 April 27, 2026, at 11:46 a.m., during an audit of the licensee's medication storage cabinet, the surveyor found the following expired medications: - a package of Refresh classic ophthalmic solution eye drops belonging to R2. The medication had an expiration date of April 25, 2026. The surveyor also identified the following undated time sensitive medications: - a bottle of Systane lubricant eyedrops belonging to R3. The manufacturer's label printed on the packaging indicated the medication was to be disposed of 90-days after first opening; - two fluticasone propionate salmeterol diskus inhalation powder 250mcg/50mcg inhalers belonging to R3. The inhalers had a label on the front which had a place to label the date opened and the use by date. One of the two inhalers had a sticker placed on it which indicated the inhaler should be disposed 30-days after starting; - a bottle of refresh liquigel 1% ophthalmic solution belonging to R3. The manufacturer's label printed on the packaging indicated the medication was to be disposed of 90-days after first opening; - two undated Humalog 200 units/ml kwikpens belonging to R2; and - one undated Latus Solostar 100 units/injection pen belonging to R2.	01890		

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01890	Continued From page 37 On April 27, 2026, at 12:02 p.m., clinical nurse supervisor (CNS)-B stated staff were trained to label time sensitive medications. CNS-B stated they would provide reeducation to ensure the requirement was completed by staff in the future. The licensee's 7.11 Medication Storage policy dated July 30, 2021, indicated medications will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Food & Beverage Inspection Report

Establishment Info

Morning Glory Homes Incorporat
4328 WILLISTON ROAD
Minnetonka, MN 55345
Hennepin County
Parcel:

Phone:

License Info

License: HFID 31881

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

Inspection Info

Report Number: F1047261124
Inspection Type: Full - Single
Date: 4/28/2026 Time: 10:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: NO STATE CERTIFIED FOOD PROTECTION MANAGER FOR THE FACILITY. STAFF MEMBERS ARE TAKING THE EXAM TODAY AND WILL BE SUBMITTING THE CERTIFICATE TO MDH.
Comply By: 5/28/2026 Originally Issued On: 4/28/2026

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG AT TIME OF INSPECTION. SAMPLE LOG PROVIDED WITH REPORT.
Comply By: 4/28/2026 Originally Issued On: 4/28/2026

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator Z. Morth.

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

The kitchen has a two basin sink. The kitchen has an additional sink designated for handwashing. A residential dish machine is located in the kitchen.

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1047261124 from 4/28/2026

Holly Green

_____ _____

Kenneth Kohn
Operator

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Morning Glory Homes Incorporat
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F1047261124
Inspection Type: Full
Date: 4/28/2026
Time: 10:00 am

Food Temperature: Product/Item/Unit: Cut canteloupe**; Temperature Process:** Cold-Holding
Location: Refrigerator at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Morning Glory Homes Incorporat
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F1047261124
Inspection Type: Full
Date: 4/28/2026
Time: 10:00 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 180 Degrees F.
Comment: Per operator's test strip
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL31881016-0	**Date:** 4/27/2026
Facility Name: MORNING GLORY HOMES	
Facility Address: 4328 Williston Rd, Minnetonka, Minnesota 55345	

☒ **TAG IDENTIFICATION: 0775**

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

   Comments: The door leading from the basement of the assisted living into the garage was marked with an exit sign leading occupants through the garage as an exit. The storage conditions inside the garage created a fire hazard and impeded safe access and movement within the space. The door leading from the assisted living to the garage shall not be marked as an exit and lead occupants through the garage as an exit as the garage is a higher hazard area than the assisted living area.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: Inside the mechanical room, two electrical extension cords were being used to supply power to the sump pump and the furnace through a relocatable power strip.

4. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments: There was an electrical junction box in the basement mechanical room that did not have a cover installed exposing the electrical wires.

5. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: It was observed there was not a carbon monoxide alarm installed outside and within 10 feet of all sleeping rooms. Inside the mechanical room the carbon monoxide was missing off its bracket and staff were unable to locate it.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: During the survey, it was noted that the smoke alarms in the facility were not interconnected. Multiple brands of alarms were installed, and testing showed that not all units would activate simultaneously as an interconnected system. Agent-A stated that he replaced the alarms in the resident rooms but did not extend the interconnected system throughout the remainder of the facility. Due to the facility's size and multiple levels, alarm activation in the basement would not be able to be heard by residents and staff on the third level.

☒ **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: Fire extinguishers throughout the facility were found placed on the floor rather than in approved brackets. Fire extinguishers were also missing their required monthly maintenance inspection checks in accordance with Minnesota State Fire Code 906.

2. Portable fire extinguishers have a minimum 2-A:10-B:C rating within Group R-3 occupancies and travel distance to the nearest fire extinguisher does not exceed 75 feet. [Minn. Stat. 144G.45 subd.2]

   Comments: During the survey, a 1-A:10-B:C fire extinguisher was noted to be in use in the basement adjacent to the laundry room.

☒ **TAG IDENTIFICATION: 0800**

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

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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: Inside the garage, there was an excessive accumulation of combustible materials. The stored items included, but were not limited to, cardboard boxes, dining and bedroom furniture, mechanical equipment, and other household goods. In addition to the combustible storage, chemical accelerants were kept in the same area, both above and immediately adjacent to these materials. These chemicals included old paint cans, flammable liquids, and multiple gas cans. The door to the garage was identified as an emergency exit in the event of a fire. The storage conditions created a fire hazard and impeded safe access and movement within the space.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: Surveyor requested the FSEP from administrator (A)-A at 1:00 p.m. At 1:15 p.m., A-A returned stating that it was not on site.

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: Surveyor was unable to review the FSEP for employees. A-A stated that no updates were made to the FSEP from the previous survey conducted on June 10, 2024.

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

Comments: Surveyor was unable to review the FSEP for residents. A-A stated that no updates were made to the FSEP from the previous survey conducted on June 10, 2024.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) 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: Licensee failed to provide documentation that identified 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.

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

   Comments: Licensee failed to provide documentation of staff training on the FSEP.

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: Licensee failed to provide documentation of resident training on the FSEP.

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

   Comments: Licensee failed to provide documentation that indicated they conducted evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month.