Electronically Delivered

January 15, 2026

Licensee
Thrive Better Assisted Living
2518 Washington Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL38677016

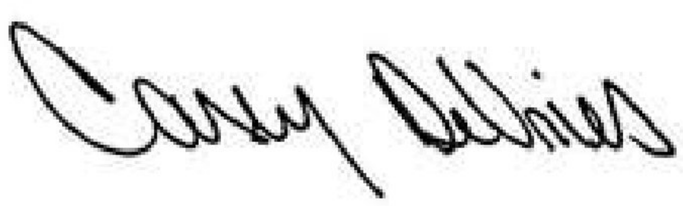
Dear Licensee:

On December 22, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 14, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

CLN

Electronically Delivered

November 3, 2025

Licensee
Thrive Better Assisted Living
2518 Washington Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL38677016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 14, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
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 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $1,000.00
St - 0 - 0510 - 144g.41 Subdivision 3 - Infection Control - $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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38677	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE BETTER ASSISTED LIVING	2518 WASHINGTON STREET NE MINNEAPOLIS, MN 55418

(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: SL38677016-0 On October 13, 2025, through October 14, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license. On October 13, 2025, an immediate order was identified for SL38677015-0 tag identification 0470.	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=G	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there was sufficient staffing 24 hours per day, seven days per week, to meet the scheduled and reasonably foreseeable unscheduled needs of each resident and to ensure the licensee could respond promptly and effectively in the event of an	0 470	On October 14, 2025, the licensee submitted a plan of correction with appropriate actions taken to address the immediate risk. The scope and severity level of the order will remain the same.	

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0 470	Continued From page 2 emergency for one of one resident (R2). Further, the licensee failed to ensure their daily staffing schedule was posted to reflect their current staffing needs. 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 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: OVERNIGHT STAFFING IMMEDIATE ORDER The licensee held an assisted living facility license. The facility was licensed for a capacity of five residents, and during the survey had a census of five residents. The licensee's Staffing Plan last updated on September 8, 2025, indicated two unlicensed personnel (ULP) were the required number of direct care staff needed to meet their resident's needs. The licensee's employee schedule for October 13 through 20, 2025, indicated two ULP were scheduled to work the day and evening shift, and one ULP was scheduled to work the overnight shift. R2 was admitted to the licensee on July 28, 2024. R2's Addendum to Contract service plan dated August 1, 2025, indicated R2 received services	0 470		

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0 470	Continued From page 3 including assistance with bathing, transfers, repositioning and meals. R2's Individualized Abuse Prevention Plan (IAPP) dated September 21, 2025, indicated R2 required two staff members to assist the resident with transferring using a Hoyer lift to and from their bed and wheelchair (w/c). R2's 90 Day Assessment dated September 21, 2025, indicated R2 required two staff members to assist the resident with transferring using a Hoyer lift to and from their bed and w/c. On October 13, 2025, at 10:00 a.m., during the entrance conference, the surveyor observed a black and grey manual Drive Hoyer lift in the downstair living room corner. Clinical nurse supervisor (CNS)-A stated they had one resident, R2, who required a two-person Hoyer lift transfer. Licensed assisted living director (LALD)-D stated one staff member could operate a Hoyer lift on their own; CNS-A corrected LALD-D stating two staff members were required to operate the Hoyer lift. CNS-A stated they only had one staff member, a ULP, working the overnight shift. CNS-A stated R2's cancer had progressed and R2 was no longer able to walk; R2 did not want to get out of bed so they no longer needed a Hoyer lift transfer. The surveyor inquired what the overnight staff member would do in the event of an emergency such as a fire or evacuation of the building. CNS-A stated they could put another ULP on-call. The surveyor explained a second staff member on-call offsite would not meet the immediate needs and transfer assistance for a resident. On October 13, 2025, at 10:27 a.m., the surveyor	0 470		

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0 470	Continued From page 4 observed ULP-B and ULP-C cleaning R2's room. ULP-B and ULP-C's Home Health Aide Competency Evaluation dated April 8, 2025, and February 6, 2025, respectively, indicated ULP-B and ULP-C completed Hoyer lift training. The training indicated two staff members were required to operate the Hoyer lift. On October 13, 2025, at 10:35 a.m., ULP-B stated two ULPs worked the day and evening shift and one ULP was there in the morning when they arrived for their shift. On October 13, 2025, at 11:14 a.m., ULP-B stated they were trained to only complete a Hoyer lift transfer with two staff members. The surveyor inquired how they would get R2 up to the main level in the event of an emergency since there were six steps to climb. ULP-B stated they would probably need two to three staff members to get R2 up the stairs. ULP-B stated there was not an exit on the basement level of the facility. On October 13, 2025, at 11:18 a.m., LALD-D stated R2's case manager (CM)-E was able to assist with securing payment to install a stair lift in the facility for R2. LALD-D confirmed there was not an exit on the basement level of the facility. LALD-D stated R2 had been unable to walk for approximately the past three months and was currently on hospice care. LALD-D stated they had not had a reason to move R2 from the basement since they were first unable to walk. On October 13, 2025, at 11:22 a.m., CNS-A stated they had tried in the past to get R2 and CM-E to hire additional assistance by hiring extra	0 470		

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0 470	Continued From page 5 help for the overnight shift but had been unsuccessful. The surveyor explained it was up to them to find a solution to meet the residents' needs. On October 13, 2025, at 1:26 p.m., CNS-A stated they were unsure if they had a transfer policy which would address two-person transfers or Hoyer lifts transfers. CNS-A stated they considered two-person Hoyer lifts as a standard of practice. STAFF SCHEDULE POSTED On October 13, 2025, the surveyor observed ULP-B and ULP-C providing cares to residents throughout the day. On October 13, 2025, at 9:46 a.m., during the entrance conference, LALD-D stated their daily staffing schedule was posted upstairs in the kitchen. CNS-A and LALD-D stated two ULPs worked the morning and evening shift, and one ULP worked the night shift. On October 13, 2025, at 10:05 a.m., during the facility tour, the surveyor observed the licensee's Staffing Schedule dated October 13, 2025 through October 20, 2025, posted on a bulletin board in the kitchen; it indicated there was one ULP scheduled for the morning, evening and night shift. On October 13, 2025, at 10:31 a.m., ULP-B stated two ULPs worked during the morning and evening shift. On October 13, 2025, at 10:35 a.m., LALD-D stated the posted schedule only had one ULP scheduled for the morning and evening shift	0 470		

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0 470	Continued From page 6 which was inaccurate; there were actually two ULPs working the morning and evening shift. LALD-D stated they would provide an updated schedule to include two ULPs on the morning and evening shift. On October 13, 2025, at 11:18 a.m., LALD-D provided an updated Staffing Schedule dated October 13, 2025 through October 20, 2025, which included two ULPs schedule for the morning and evening shift, and one ULP scheduled for the night shift. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and	0 510		

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0 510	Continued From page 7 nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 October 13, 2025, at 10:05 a.m., during the facility tour, the surveyor observed the facility was a four level home with a main floor, upstairs, lower level and basement level. The surveyor observed the lower level and upstairs bathroom lacked paper towels for hand drying. On October 13, 2025, at 2:15 p.m., the surveyor observed the upstairs bathroom was stocked with paper towels for hand drying. The surveyor observed the lower level bathroom still lacked paper towels for hand drying; the surveyor touched the bathroom doorknob which was wet. On October 14, 2025, at 1:13 p.m., the surveyor sent an email to licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A which requested hand washing and infection control policies, questions for CNS-A regarding their paper towel refilling process and the effect it had on hand washing hygiene. On October 15, 2025, at 8:59 a.m., LALD-D's	0 510		

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0 510	Continued From page 8 email indicated: "Hello [surveyor], Yes attached is the MDH hand washing policy we follow and yes step 6 is how we turn off water with paper towel. Refilling paper towels in an assisted living facility is a crucial task that ensures residents have access to clean and hygienic hand-drying options. Here's a step-by-step guide on how to refill paper towels at [licensee]: - Step 1: Check the paper towel dispensers regularly to ensure they are not empty or running low. - Step 2: Restock paper towels by bringing in new rolls or stacks of paper towels to the dispensers. - Step 3: Replace the empty roll with a new one, making sure it's securely fastened to the dispenser. - Step 4: Dispose of the cardboard core and any leftover paper towel scraps. - Step 5: Clean the dispenser if necessary to prevent any buildup of dirt or bacteria. Not having paper towels can significantly affect hand-washing hygiene in several ways: - Inadequate drying: Without paper towels, residents may be forced to air-dry their hands or use their clothing, which can lead to inadequate drying and increased bacterial growth. - Cross-contamination: If residents are forced to share towels or use communal cloths, it can lead to cross-contamination and the spread of infections. - Poor hand hygiene: If residents don't have access to clean paper towels, they may be less likely to wash their hands properly or at all, which can compromise hand hygiene and increase the risk of infections. In [licensee] facility, it's essential to prioritize hand hygiene and ensure that paper towels are	0 510		

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0 510	Continued From page 9 always available to residents. This can be achieved by: - Implementing a routine restocking schedule to ensure paper towels are always available. - Providing alternative hand-drying options, such as warm air blowers, if paper towels are not feasible. - Ensuring proper hand hygiene practices are followed, such as washing hands with soap and water for at least 15 seconds and drying them completely. - Educating staff and residents on the importance of hand hygiene and proper paper towel use. By prioritizing paper towel refilling and hand hygiene, [licensee] can help prevent the spread of infections and maintain a clean and healthy environment for residents. I am going to scan our infection control plan and send in the next email before end of the day. Thank you" No response was received from CNS-A regarding paper towels and their effect on hand hygiene. The Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers website dated February 27, 2024, indicated: "Know how to wash hands with soap and water 1.Wet hands with water. 2. Apply the manufacturer recommended amount of product to your hands. 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. 5. Avoid using hot water to prevent drying of the skin.	0 510		

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0 510	Continued From page 10 Note: Other entities recommend cleaning hands with soap and water for at least 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times and scrubbing hands and fingers with soap" The licensee's Refilling Paper Towels policy, undated, indicated the same information as provided in the previously noted October 15, 2025, 8:59 a.m., email. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency phone number in common areas and near telephones provided by the assisted living facility. This had the	0 640		

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	38677	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE BETTER ASSISTED LIVING	2518 WASHINGTON STREET NE MINNEAPOLIS, MN 55418

(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
0 640	Continued From page 11 potential to affect all residents, staff, and visitors at 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at 10:05 a.m., during the facility tour, the surveyor observed the facility was a four level home with a main floor, upper level, lower level and basement level. On October 13, 2025, at 2:15 p.m., the surveyor observed R4 return a VTech cordless house phone onto its docking station after using it in the lower level of the facility. The surveyor observed 911 was not posted near the phone or in the basement level. On October 14, 2025, at 12:05 p.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated the house phones were for use by the residents and staff and would post 911 near house phones immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

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	38677	A. BUILDING: _____ B. WING _____	10/14/2025

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0 680	Continued From page 12	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and display prominently a written emergency preparedness plan (EPP) with all the required content for staff, residents, and visitors to view. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 13 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at 10:05 a.m., during the facility tour, the surveyor observed the facility was a four level home with a main floor, upper level, lower level and basement level. The facility lacked a prominently posted emergency disaster plan. On October 14, 2025, at 11:02 a.m., licensed assisted living director (LALD)-D provided the licensee's Emergency Preparedness Manual dated February 17, 2025, and stated they stored it in their filing cabinet drawer. On October 14, 2025 at 11:55 a.m., the surveyor observed the EPP in the filing cabinet drawer. LALD-D stated they were unaware it was required to be displayed prominently and would post signage directing people where to find the EPP. The licensee's Emergency Preparedness policy dated June 12, 2022, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." 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		
0 800 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 and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 800	Continued From page 15 The findings include: On October 13, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed. In resident room 5 the light fixture was missing the globe. Directly outside of resident room 5 in the common hallway the light fixture was also missing the globe. LALD-D said that they would install the globes. The egress window in resident room 5 was being blocked by a cover that prevented LALD-D from opening the window. LALD-D stated that in the event of an emergency someone would remove the cover so that the resident could open the window. LALD-D removed the cover during survey, and it was confirmed that the window opened fully. In resident room 2 the egress window was missing the handle. The handle was located laying on the windowsill. LALD-D was unable to attach the handle to open the window. The carbon monoxide alarm on the first floor would not sound when tested by LALD-D. LALD-D replaced the batteries and tested the carbon monoxide alarm. LALD-D installed the carbon monoxide alarm during survey. There were two holes in the drywall behind the main entry door from the handle and deadbolt lock. LALD-D confirmed the holes in the wall.	0 800		

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0 800	Continued From page 16 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, 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.	0 810		

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0 810	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated June 12, 2022, failed to include the following: 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 provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810		

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0 810	Continued From page 18 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least annually, or every 12 months, 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 to the licensee on June 28, 2024.	01830		

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01830	Continued From page 19 R2's Addendum to Contract service plan dated August 1, 2025, indicated R2 received services including assistance with medication management. R2's Med Admin Summary (medication administration record (MAR)) for October 2025, indicated R2 was scheduled to take the following medications: -buspirone 15 milligram (mg) tablet, take two tablets (30 mg) by mouth (PO) daily; -docusate sodium 100 mg, take one capsule PO twice daily; -duloxetine 60 mg delayed release (DR) capsule, take one capsule PO twice daily; -gabapentin 300 mg capsule, take two capsules (600 mg) PO twice daily at 8:00 a.m. and 2:00 p.m.; -gabapentin 300 mg capsule, take three capsules (900 mg) PO at bedtime; -metformin 500 mg extended release (ER) tablet, take two tablets (1000 mg) PO daily with meals; -omeprazole 20 mg DR capsule, take one capsule PO once daily; -perphenazine 8 mg tablet, take two tablets (16 mg) PO daily; -risperidone 2 mg tablet, take one tablet PO twice daily; -tamsulosin 0.4 mg capsule, take one PO once daily; and -trazodone 100 mg tablet, take one and a half tablets (150 mg) PO at bedtime. R2's record included signed medication orders dated July 15, 2024, which included the above-listed medications, with the following differences: -gabapentin 300 mg capsule, take one capsule	01830		

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01830	Continued From page 20 by mouth twice daily every morning and with lunch: 8:00 a.m. and 2:00 p.m.; -risperidone 1 mg tablet, take one tablet PO twice daily; and -trazodone 50 mg tablet, take one tablet PO at bedtime. R2's record lacked current signed medication orders renewed at least every 12 months. On October 14, 2025, 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with medication administration including the following medications: Tylenol 100 mg Buspar 15 mg docusate sodium duloxetine 60 mg gabapentin 600 mg metformin 1000 mg omeprazole 20 mg DR cap perphenazine 8 mg rispiradone 2 mg On October 14, 2025, at 9:13 a.m., clinical nurse supervisor (CNS)-A stated the medication orders from July 15, 2024, were the only orders they had for R2 which were over 12 months old. CNS-A stated R2 received hospice care and hospice was managed R2's medication orders. CNS-A stated it was challenging to stay current with orders when hospice was involved. The surveyor explained hospice involvement did not remove their responsibility to ensure R2 had their medication orders renewed every 12 months when managing a residents medication. CNS-A stated they were going to contact hospice regarding R2's medication orders.	01830		

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01830	Continued From page 21 On October 14, 2025, at 9:30 a.m., hospice registered nurse (RN)-E stated they would obtain updated orders for all of R2's medications. On October 14, 2025, 9:50 a.m., RN-E provided current medication orders signed on October 14, 2025, (signed during survey) which included medications as administered and as listed on R2's MAR. The licensee's Medication Orders policy dated June 12, 2022, indicated, "2. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		

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

Thrive Better
2518 Washington Street NE
Minneapolis, MN 55418
Hennepin County
Parcel:

Phone:

License Info

License: 0041193

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Osman Aden
CFPM #: CFPM-55379; Exp: 1/20/2028

Inspection Info

Report Number: F1039251160
Inspection Type: Full - Single
Date: 10/14/2025 Time: 11:30:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

This inspection was completed as part of an MDH HRD assisted living facility survey. The inspection was conducted with the persons-in-charge and reviewed with MDH HRD nurse evaluator Joey Keen.

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, wood floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair, clean and well maintained.

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

A residential dishwashing machine is present in the kitchen. Log of dishwashing machine rinse temperatures shows rinse temperature >160 degrees F

Verified hand sink correctly set-up, gloves, illness policy, probe thermometer, irreversible waterproof temperature test strips.

Discussed the following with the persons-in-charge: minimum cook temps for animal proteins, food source, date marking, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing.

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 F1039251160 from 10/14/2025

Osman Aden
person-in-charge

Aron Goodner,
Public Health Sanitarian 1
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

Temperature Observations/Recordings

Establishment Info

Thrive Better
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1039251160
Inspection Type: Full
Date: 10/14/2025
Time: 11:30:00

Equipment Temperature: Product/Item/Unit: REFRIGERATOR**; Temperature Process:** Ambient Air
Location: at 40 Degrees F.
Comment: FREEZER - FROZEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: BEEF STEW ON STOVE**; Temperature Process:** Cooking
Location: at 184 Degrees F.
Comment:
Violation Issued?: No