



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 27, 2026

Licensee

A-A-H Mercy Home Health
3554 June Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL33981016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 6, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted no 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:

0340 - 144g.30 Subd. 5 - Correction Orders - \$1,000.00

0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting Ma - \$1,000.00

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

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33981	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER A-A-H MERCY HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 3554 JUNE AVENUE NORTH ROBBINSDALE, MN 55422			
(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: SL33981016-0 On May 4, 2026, through May 6, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the Assisted Living Facility license. Immediate correction orders were identified on May 5, 2026, issued for SL33981016-0, tag identification 0630 and 1730. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 340 SS=G	144G.30 Subd. 5 Correction orders	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 (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 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 interview and record review, the licensee failed to provide sufficient documentation of actions taken to comply with the correction orders from a survey completed May 11, 2024, and follow up survey completed July 8, 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 three violation (a violation that harmed a resident's health or safety,	0 340			

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0 340	Continued From page 2 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: On May 9, 2024, and July 22, 2024, the licensee received results from the previous surveys concluded on April 11, 2024, and July 8, 2024, respectively. The re-issued orders received by the licensee on July 22, 2024, included no time period for correction (the time frame by which the licensee must document and correct orders) due to the orders initially being issued on May 9, 2024, during the initial survey with an initial time period for correction, which had elapsed. The licensee's correction orders included, in part, tag identifier 0470, 144G.41 Subdivision 1. (11-12) Minimum requirements related to staff scheduling and tag identifier 0630, 144G.42 Subd. 6. (b) Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. The licensee's Survey Plan of Correction (POC) dated April 15, 2026, through April 22, 2026, included the following content and read: - "Tag 0470 - Daily Care Requirements What was fixed: The facility reviewed daily care practices and corrected areas that were not meeting state rules which was (sic)identified during the survey (sic). What changed for everyone: Staff were reminded about daily care duties, resident safety, and following facility policy. Staff were retrained in Rtask [a documentation software] service charting	0 340			

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0 340	Continued From page 3 How we will check: Management will review staff practices every month. Date Fixed: April 19, 2024"; and - "Tag 0630 - Abuse Prevention What was fixed: Resident safety plans were reviewed and updated where needed. Addition poster were (sic) posted and residents were made aware of their rights What changed for everyone: Each resident will have a plan that looks at their safety needs and ways staff can protect them. How we will check: Resident files will be reviewed every three months. Date fixed April 17, 2024." On May 6, 2026, at 9:55 a.m., administrator (A)-E stated they were still learning the statute for 0470. A-E stated prior to the surveyor explaining the statute, "we did not really know" how the staffing plan or the schedule was supposed to be completed. A-E stated they understood the statute for 0630 in a different way prior to the start of survey. A-E stated they believed they covered the required information for R1 however, now they now knew they needed to be more specific with the individual abuse prevention plan. The surveyor did not receive an additional POC from the licensee post follow up survey which occurred on July 8, 2024. During the survey initiated on May 4, 2026, and exited on May 6, 2026, areas of deficient practice related to tags 0470, and 0630 were identified and the correction orders were re-issued. No further information was provided.	0 340			

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0 340	Continued From page 4	0 340			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to	0 470			

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0 470	Continued From page 5 review as required. In addition, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee received a correction order, tag identification 0470, following an initial survey that concluded on April 11, 2024, and was re-issued the correction order after a follow up survey that that concluded July 8, 2024. The licensee's Survey Plan of Correction (POC) dated April 15, 2026, through April 22, 2026, included the following content and read: - "Tag 0470 - Daily Care Requirements What was fixed: The facility reviewed daily care practices and corrected areas that were not meeting state rules which was identified during the surview (sic). What changed for everyone: Staff were reminded about daily care duties, resident safety, and following facility policy. Staff were retrained in Rtask [a documentation software] service charting How we will check:	0 470			

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0 470	Continued From page 6 Management will review staff practices every month. Date Fixed: April 19, 2024" SCHEDULE On May 4, 2026, at 10:05 a.m., during a facility tour, the surveyor observed a posted schedule titled 2023/2024 Staff Schedule. The document included a table with the following information: - first column included names of employees; - top row included the days of the week, Monday through Sunday; and - times of shifts that would be worked which corresponded to the employee's name and the day of the week. The staff schedule was not dated with the dates that Monday through Sunday corresponded to. The document did not meet the requirements of a staff schedule. During the tour O-A stated the licensee had long-term employees and every employee showed up for their shifts. O-A stated the licensee's schedule was stable and did not change so "we did not make a date" to the schedule. STAFFING PLAN The licensee's Facility Staffing Plan dated 2022 indicated the licensee required two staff to be present in the facility at all times. In addition, the staffing plan was prepared by owner (O)-A. The staffing plan lacked evidence it was reviewed twice per year and was not created by the clinical nurse supervisor (CNS). On May 5, 2026, at 12:55 p.m., CNS-C stated they did not determine who worked each day however they determined if the facility needed one or two staff to be present. CNS-C stated they did not create the paperwork for the staffing plan, but they did tell the person who created the	0 470			

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0 470	Continued From page 7 staffing plan how many staff were needed in the facility at any given time. CNS-C stated they do not do anything related to the daily staff schedule. On May 6, 2026, at 9:55 a.m., administrator (A)-E stated they were still learning the statute for tag 0470. A-E stated prior to the surveyor explaining the statute, "we did not really know" how the staffing plan or the schedule was supposed to be completed. In addition, A-E stated O-A created the daily staff schedule. The licensee's Staffing policy dated December 14, 2022, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet the residents' needs at all times, including reasonably foreseeable needs. The staffing plan would be reviewed at least twice per year. In addition, the daily staffing schedule was prepared by the CNS and would be posted at the beginning of the shift in a central location accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 8 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, 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	0 480			

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0 480	Continued From page 9 surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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, Food and Beverage Establishment Inspection Report (FBEIR) dated May 5, 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			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485			

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0 485	Continued From page 10 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Assisted Living Contract	0 485			

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NAME OF PROVIDER OR SUPPLIER A-A-H MERCY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 3554 JUNE AVENUE NORTH ROBBINSDALE, MN 55422		
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0 485	Continued From page 11 dated 2022 included the following statement, "Subject to the Resident's needs, [the licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [the licensee] staff at the following times: 7:00 AM Breakfast 12:00 PM Lunch 6:00 PM Dinner". The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee and lacked the option to opt out of the meal plan. On May 5, 2026, at 1:30 p.m., administrator (A)-E stated the blank contract was used for all residents who resided in the facility. A-E stated they were not aware the contract could not include meals as part of their base fee. A-E stated they did not charge for meals, and they would remove the section from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 630 SS=G	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;	0 630			

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0 630	Continued From page 12 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 observation, interview, and record review, the licensee failed to address R1's known self-abuse vulnerability on their individual prevention plan (IAPP) and failed to have statements of specific measures to be taken to minimize the risk of abuse to that person for one of two residents (R1). 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: R1 was admitted to the licensee on February 3, 2023, and began receiving assisted living services. R1's diagnoses included schizophrenia (a mental health condition that affects how people think, feel and behave, often causing a loss of touch with reality), anxiety disorder, attention-deficit hyperactivity disorder (ADHD), nicotine dependence, and mood disorder. R1's Addendum to Contract - Waiver - MN signed February 25, 2025, indicated R1 received	0 630			

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0 630	Continued From page 13 assistance with appointments, bathing reminders, dressing, transportation, grooming, housekeeping, behavior management including self-injurious behavior and orientation management, meals, medication administration, safety checks, shopping, socialization, and monitoring smoking. On May 4, 2026, at approximately 10:05 a.m., during a facility tour, with permission, the surveyor entered R1's room. The surveyor observed an open dresser drawer which contained multiple syringes, cigarette butts, and other miscellaneous items. R1 quickly closed the drawer. The surveyor requested to see the drawer again. The surveyor then observed at least seven hypodermic syringes. At least two of the visible syringes had uncapped needles attached. Without moving items within the drawer, the surveyor was unable to view the tip of the other five visible syringes. R1's record included two documents titled Drugs Free Facility Policy signed September 17, 2023, and February 16, 2024. The documents indicated the following: - the assisted living facility (ALF) was a drug free facility; - distribution and sharing of illegal drugs on the ALF premises was grounds for violating the assisted living contract; and - the licensee may initiate a termination of the ALF contract if it is violated. R1's record included an untitled assessment document from a mental health services program dated January 4, 2023, which indicated the following: - R1's drug of choice was opiate; - R1 had been on methadone for three years;	0 630			

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0 630	Continued From page 14 - R1 started using heroin in 2005 and would use weekly however, it turned to daily; - R1 started to use Percocet in 2004 and would use daily; - R1 started to use cocaine at 18 years old and R1 would use once a weekend or once a month; - R1 reported they completed three years of back-to-back chemical dependency treatment from 2015 to 2018; - R1 had a risk of abuse to self with his substance use, with history of IV opiates, and most recent Fentanyl; and - R1 had suicidal ideation "all the time". R1's IAPP completed February 3, 2023, indicated R1 had a history of drug and alcohol abuse, R1 may not use alcohol or chemicals while residing at the facility, staff were to report any use of alcohol or chemicals by R1 to nurse promptly. R1's record included a letter from a mental health provider from an intensive residential treatment services program dated June 27, 2024, which indicated the following: - the prescriber believed R1 needed to be referred to a higher level of care due to recent disclosure of ongoing IV/IM opioid use over the last month; - R1 declined a medically supervised detoxification recommendation; and - R1 acknowledged the recommendations as well as the risks of declining the recommendations and intended to return to the licensee where they previously lived. R1's record included an After Visit Summary (AVS) dated December 24, 2024, indicating R1 was seen for substance abuse and acute brain disorder.	0 630			

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0 630	Continued From page 15 R1's Med Admin Summary -Actual - Month dated May 2026 included "Naloxone Hydrochloride [Narcan (opioid antagonist medication used to rapidly reverse the effects of opioid overdose)] As Needed Use 1 spray in a nostril. Call 911 if no response in 2 - 3 minutes. Repeat does (sic) in another nostril. Administration instructions:" The instructions lacked an indication for use. R1's ongoing assessments completed by the licensee dated September 30, 2025, January 6, 2026, and March 31, 2026, indicated the R1 was not at risk to abuse themselves, and had no history of attempted suicide or thoughts of suicide. The assessment did not address the safety related to R1's substance use history. R1's IAPP completed April 13, 2026, indicated R1 had no known risk to abuse themselves, became irritable and agitated at times, was independent to make decisions, and had a history of mental illness. R1's IAPP lacked information related to substance use and lacked interventions to prevent self-abuse to R1. R1's progress note dated April 22, 2026, indicated clinical nurse supervisor (CNS)-C reviewed R1's chart. The note read, "[R1] appears to be responding to internal stimuli. Usure (sic) if he used drugs. Per staff report, he is disoriented, irritable and agitated. I discussed with him to take the scheduled Haldol as prescribed. He is intermittently refusing Haldol and other medications at bedtime. Will continue to educate him (sic) importance of taking his prescribed medications. Will continue to monitor for safety." On May 4, 2026, at 10:53 a.m., owner (O)-A stated R1 had a history of drug use and went to treatment for a couple of months however, R1	0 630			

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0 630	Continued From page 16 had still not stopped. The surveyor inquired if they had Narcan in the facility. O-A stated they were unsure. On May 4, 2026, at 2:28 p.m., CNS-C stated R1 had a history of drug usage. CNS-C stated the licensee's staff had sent R1 to the hospital when R1 was agitated, confused, and when staff suspected drug use. The surveyor inquired what interventions the licensee had put into place for R1's drug use. CNS-C stated they have had multiple meetings for suspected drug use, and they do not allow drug use in the facility. CNS-C stated if a resident came into the facility intoxicated, they would call for treatment. CNS-C stated they had not seen R1 using drugs within the facility, and they were not aware of syringes in R1's room. CNS-C stated they knew there was a history of use, and R1 had an infection on the arm from injecting drugs, which they were monitoring. CNS-C stated they assess R1 when they see them, however, they did not conduct room searches nor had staff reported any drug use for R1. Although the licensee had awareness of R1's on-going substance use, the licensee failed to implement interventions and include statements of the specific measures to be taken to minimize the risk of self-abuse to R1. The licensee's Vulnerable Adult policy dated December 14, 2022, indicated the licensee was required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. No further information was provided.	0 630			

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0 630	Continued From page 17	0 630			
	TIME PERIOD FOR CORRECTION: Immediate				
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of three employees (clinical nurse supervisor (CNS)-C). In addition, the licensee failed to document competency evaluations with required content per Minnesota Administrative Rules chapter 4659.0190 Subp. 6. (training records and	0 650			

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0 650	Continued From page 18 documentation) for one of two unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CONTENT CNS-C was hired on May 12, 2023, to supervise ULP and provide assisted living services. CNS-C's personnel file included a document titled Staff Profile - Supervision - Residex printed May 5, 2026. The document indicated administrator (A)-E observed CNS-C complete the service or task of documentation & compliance on March 30, 2026, scope of registered nurse (RN) supervision on April 30, 2025, and staff training on May 5, 2024. The document did not identify areas of improvement needed or training needs and lacked CNS-C's input. CNS-C's personnel file lacked the following required annual training for 2024, 2025, and thus far in 2026: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging	0 650			

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0 650	Continued From page 19 behaviors, and how to communicate with resident who have dementia, Alzheimer's disease, or related disorders; - principles of person - centered planning / service delivery; and - two hours of dementia training. On May 4, 2026, at 1:38 p.m., via email, the surveyor requested CNS-C's personnel file. On May 5, 2026, at 11:10 a.m., 12:07 p.m., and 12:31 p.m., the surveyor requested a new print out of CNS-C's EduCare (a training software) transcript. At 12:31 p.m., A-E stated CNS-C had the transcript because it was completed through a different facility. A-E stated they did not have record of the training from their facility. On May 5, 2026, at 12:07 p.m., administrator (A)-E provided the Staff Profile - Supervision - Residex document and stated the licensee conducted supervision on CNS-C annually. A-E stated they would not have a document that met the requirements of an annual performance review. On May 5, 2026, at 1:23 p.m., CNS-C stated they received the annual training listed above at another facility and had not been assigned the courses through the licensee. CNS-C stated their transcripts were located at their other place of employment. On May 5, 2026, at 1:27 p.m., CNS-C stated they had not received an annual performance evaluation from the licensee. The licensee's Performance Evaluation blank template included three different sections that were not addressed in the documents listed	0 650			

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0 650	Continued From page 20 above which included areas for improvement, educational needs, and employee comments and goals. COMPETENCY EVALUATIONS ULP-B was hired on May 12, 2023, to provide assisted living services. ULP-B's personnel file included a document titled Health Care Competency Evaluation. The form included 18 of the 22 required topics required by 144G.61, Subd. 2 for ULP that were not certified nursing assistants. The form indicated ULP-B completed an oral and practical competency on the topics on May 12, 2023, however lacked a signature from the staff member who received the training and a signature from the staff member who completed the training and competency evaluations. ULP-B's competency evaluation lacked required content from content per Minnesota Administrative Rules chapter 4659.0190 Subp. 6. The licensee's Personnel Records policy dated December 14, 2022, indicated at minimum, all documents related to the following were kept in the personnel record, as applicable to job requirements: - evidence of current professional licensure, registration or certification; - results of background studies; - records of annual training and infection control; - documentation of orientation; - documentation of supervision, as applicable; - performance reviews; - competency evaluations; - signed job descriptions; and - documentation of annual performance reviews identifying areas of improvement needed and training needs.	0 650			

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0 650	Continued From page 21 In addition, personnel records shall be maintained for at least three years after an employee ceases to be employed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 680			

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0 680	Continued From page 22 by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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 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 licensee's EPP titled Assisted Living Emergency Preparedness Manual last reviewed on February 3, 2026, lacked evidence of the following required content: - strategies for addressing facility and community-based risks which included staffing surges and shortages; - quarterly missing resident plan review; - arrangement agreements with evacuation sites; and - emergency prep testing requirements. On May 6, 2026, at 9:33 a.m., administrator (A)-E stated the missing resident plan was reviewed twice per year but they did not have documentation of the reviews. A-E stated the licensee held discussions at the monthly staffing meeting related to emergency events, however, they had not conducted emergency drills or tabletop exercises. A-E stated they had memorandums of understanding (MOU) with their	0 680			

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0 680	Continued From page 23 evacuation sites however, they would need to locate the documents in their email. The surveyor requested to review the documents. A-E stated the EPP did not address staffing shortages. Although requested, the surveyor did not receive MOUs from A-E prior to the completion of the survey. The licensee's Emergency Preparedness policy dated December 14, 2022, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 720 SS=E	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records.	0 720			

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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	
0 720	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 5, 2026, at 9:06 a.m., the surveyor requested progress notes from February 23, 2024, through June 29, 2024, and a return from hospital assessment for R1, which would have occurred around June 29, 2024. Administrator (A)-E stated the records were part of an old electronic documentation system, which they had attempted to gain access to, however, had not been successful. A-E stated once they realized they could not access their old electronic documenting system, the licensee completed a new admission assessment for the residents in Residex (a documenting software system). A-E stated the first assessment they had for R1 was dated July 8, 2024. A-E stated they would not be able to access medical records for anything completed in the electronic system prior to July 8, 2024, for two of the three residents who resided at the facility. The licensee's Clinical Record policy dated December 14, 2022, indicated the clinical record would contain pertinent health information including current and previous nursing assessments. In addition, the licensee would retain the clinical record for at least five years or as otherwise required by state or federal	0 720			

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0 720	Continued From page 25 regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 5,2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775			

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0 775	Continued From page 26	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 780			

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0 780	Continued From page 27 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 5,2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=C	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	0 790			

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0 790	Continued From page 28 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 one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 5, 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=C	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	0 800			

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0 810	Continued From page 30 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810			

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0 810	Continued From page 31 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 5,2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one	0 830			

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0 830	Continued From page 32 for three residents (R1). 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on February 3, 2023, and began receiving assisted living services. R1's diagnoses included schizophrenia (a mental health condition that affects how people think, feel and behave, often causing a loss of touch with reality), anxiety disorder, attention-deficit hyperactivity disorder (ADHD), nicotine dependence, and mood disorder. R1's Addendum to Contract - Waiver - MN signed February 25, 2025, indicated R1 received assistance with appointments, bathing reminders, dressing, transportation, grooming, housekeeping, behavior management including self-injurious behavior and orientation management, meals, medication administration, safety checks, shopping, socialization, and monitoring smoking. R1's Services Delivered- One Resident dated May 1, 2026, through May 4, 2026, indicated a smoking reminder was given at the following times:	0 830			

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0 830	Continued From page 33 - May 1, 2026, at 9:04 a.m., - May 2, 2026, at 11:44 a.m; - May 3, 2026, at 9:11 a.m; and - May 4, 2026, at 2:04 p.m. On May 4, 2026, at 9:20 a.m., the surveyor entered the facility and detected an odor of smoke throughout the facility. The surveyor observed windows open in the facility. On May 4, 2026, at approximately 10:05 a.m., the surveyor observed an open dresser drawer in R1's room which contained over ten cigarette butts, ashes, and other items. R1 stated they smoked in the front yard and in the back yard. R1 stated they brought the cigarette butts back into the facility and asserted they were not smoking in the facility. R1's progress notes dated April 1, 2026, through May 4, 2026, included note on May 1, 2026. The progress note indicated a care conference was held with R1 and administrator (A)-E related to smoking. A-E provided R1 education regarding the prohibition of smoking inside the facility including in R1's bedroom. In addition, A-E provided education on the risks of smoking indoors, designated areas R1 could smoke, and encouraged R1 to allow staff to assist with daily housekeeping to reduce the risk of fire. R1's Assessment dated May 31, 2026, included a smoking assessment portion which indicated the following: - R1 was able to demonstrate lighting, smoking, and extinguishing a cigarette; - R1 stored smoking material outside in a designated area; - R1 stated they would dispose of ashes and cigarettes in a designated area;	0 830			

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0 830	Continued From page 34 - there were no signs in R1's room of mishandled cigarettes; - there were no burn marks on R1's clothing; and - R1 was able to smoke safely, independently, without intervention. The assessment did not address R1's history of smoking in non-designated areas of the facility or any interventions the licensee had put into place related to R1's unsafe smoking. On May 4, 2026, at 10:22 a.m., during an interview with owner (O)-A and A-E, O-A stated they were not aware R1 smoked in their room. O-A stated they did not allow smoking in the room. A-E stated there had been evidence of R1 smoking in the facility, however, they had been working with R1 to resolve the issue. On May 4, 2026, at 10:29 a.m., the surveyor requested any additional progress notes related to R1's smoking including education or interventions put into place. The surveyor did not receive additional documentation other than the progress note listed above for interventions the licensee had put into place for R1's smoking. On May 4, 2026, at 2:28 p.m., via phone, clinical nurse supervisor (CNS)-C stated they had not received any reports of R1 smoking withing the facility. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2025, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may	0 830			

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0 830	Continued From page 35 smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The Minnesota Department of Health (MDH) document titled Minnesota Clean Indoor Air Act (MCIAA) dated February 12, 2026, indicated an indoor area means a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. In addition, smoking was prohibited at health care facilities and clinics. The licensee's Smoking Policy dated April 14, 2025, indicated the MCIAA would be followed to protect employees and the public from the health hazards of secondhand smoke. In addition, the licensee would ensure all occupants complied with the smoking policy and disposal of used cigarette butts. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training 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;	01500			

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01500	Continued From page 36 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following 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,	01500			

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01500	Continued From page 37 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for three of three employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-B, ULP-G). 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-C CNS-C was hired on May 12, 2023, to supervise ULP and provide assisted living services. CNS-C's personnel file lacked a review of providers policies and procedures for 2024, 2025, and thus far in 2026. ULP-B ULP-B was hired on May 12, 2023, to provide assisted living services.	01500			

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01500	Continued From page 38 On May 6, 2026, at 8:59 a.m., the surveyor observed ULP-B administer oral medication to R3. ULP-B's personnel file included an undated EduCare (training software) transcript. The document indicated training on emergency preparedness occurred on January 31, 2026 (2.5 hours (hr)), mental health training occurred on February 14, 2026 (2 hr), and a dementia course occurred on February 14, 2026 (0.5 hr). ULP-B's transcript did not contain training for 2024 or 2025. In addition, ULP-B's personnel file included a Food Safety course on January 15, 2024, that did not list the number of hours it took to complete. ULP-B's record lacked the following required training topics for the years 2024, 2025, and thus far in 2026: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control; - 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; - review of the providers policies and procedures; and - 1.5 hours (for a total of two hours) of dementia training. In addition, ULP-B's record lacked three hours of annual training for the year 2025 and thus far in 2026. ULP-G ULP-G was hired on May 20, 2024, to provide assisted living services.	01500			

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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
01500	Continued From page 39 On May 5, 2026, at 8:51 a.m., the surveyor observed ULP-G administer oral medication to R3. ULP-G's personnel file included an undated EduCare transcript which indicated ULP-G received 33.75 hours of training from June 29, 2025, to May 5, 2026. ULP-G's record lacked the following required training topics for the year 2025, and thus far in 2026: - infection control techniques; and - review of provider's policies and procedures. On May 5, 2026, at 11:10 a.m., 12:07 p.m., and 12:31 p.m., the surveyor requested a new print out of CNS-C's EduCare (a training software) transcript. At 12:31 p.m., A-E stated CNS-C had the transcript because it was completed through a different facility. A-E stated they did not have record of the training onsite from their facility. On May 5, 2026, at 1:23 p.m., CNS-C stated the licensee used EduCare to complete their annual training and owner (O)-A assigned the training in EduCare to employees. CNS-C stated staff received initial training and annual training. CNS-C stated they completed their annual training at another facility and had not been assigned the courses through the licensee. CNS-C stated their transcripts were located at their other place of employment. On May 5, 2026, at 1:32 p.m., administrator (A)-E stated the licensee provided annual training and emergency preparedness training every six months. A-E stated the licensee used EduCare and in person training to complete annual training. A-E verified ULP-B and ULP-G's employee records lacked the content listed above and stated, "oops we will have to do that."	01500			

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01500	Continued From page 40 On May 6, 2026, at 9:29 a.m., A-E stated the licensee used the document titled EduCare Annual Training Checklist - Caregiver for their annual training policy. The checklist indicated the following courses would total to the eight required training hours and included the following topics: - infection control; - assisted living bill of rights; - vulnerable adult; - person centered care - dementia training - emergency disaster and preparedness plan; - organization policies and procedures; and - mental illness and de-escalation training. On May 6, 2026, at 9:52 a.m., A-E stated O-A was the person responsible for assigning the courses in EduCare. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=E	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 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	01620			

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01620	Continued From page 41 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 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620			

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01620	Continued From page 42 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee on February 3, 2023, and began receiving assisted living services. R1's diagnoses included schizophrenia (a mental health condition that affects how people think, feel and behave, often causing a loss of touch with reality), anxiety disorder, attention-deficit hyperactivity disorder (ADHD), nicotine dependence, and mood disorder. R1's Addendum to Contract - Waiver - MN signed February 25, 2025, indicated R1 received assistance with appointments, bathing reminders, dressing, transportation, grooming, housekeeping, behavior management including self-injurious behavior and orientation management, meals, medication administration, safety checks, shopping, socialization, and monitoring smoking.	01620			

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01620	Continued From page 43 R1's record included ongoing 90-day assessments completed on September 30, 202, and January 6, 2026, which indicated 98 days passed between the assessments. R3 R3 was admitted to the licensee on January 1, 2022, and began receiving assisted living services. R3's diagnoses included schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms such as depression and mania), bipolar (mental health condition characterized by significant mood swings, including manic episodes and depressive episodes), and traumatic brain injury (TBI). R3's record included ongoing assessments dated September 30, 2025, and January 2, 2026, which indicated 94 days passed between assessments. On May 5, 2026, at 1:21 p.m., clinical nurse supervisor (CNS)-C stated the licensee conducted preadmission, initial, 14-day, 90-day, and change of condition assessments. CNS-C stated Residex (a documenting software) changed their system on how to lock a nursing assessment and did not provide training on the change. CNS-C stated the assessmentss were completed on time however, the assessments did not lock because they did not push complete two times. CNS-C stated the assessments were dated for the day the assessments were locked in the computer system. The licensee's Assessment and Reassessment	01620			

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01620	Continued From page 44 policy dated December 14, 2022, indicated ongoing resident assessments must be conducted by a RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01730 SS=G	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered	01730			

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01730	Continued From page 45 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management plan to include all required content and failed to appropriately implement the individualized medication management plan for one of two residents (R1). 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: R1 was admitted to the licensee on February 3,	01730			

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01730	Continued From page 46 2023, and began receiving assisted living services. R1's diagnoses included schizophrenia (a mental health condition that affects how people think, feel and behave, often causing a loss of touch with reality), anxiety disorder, attention-deficit hyperactivity disorder (ADHD), nicotine dependence, and mood disorder. R1's Addendum to Contract - Waiver - MN signed February 25, 2025, indicated R1 received assistance with appointments, bathing reminders, dressing, transportation, grooming, housekeeping, behavior management including self-injurious behavior and orientation management, meals, medication administration, safety checks, shopping, socialization, and monitoring smoking. On May 4, 2026, at approximately 10:05 a.m., during a facility tour, with permission, the surveyor entered R1's room. The surveyor observed an open dresser drawer which contained multiple syringes, cigarette butts, and other miscellaneous items. R1 quickly closed the drawer. The surveyor requested to see the drawer again. The surveyor then observed at least seven hypodermic syringes. At least two of the visible syringes had uncapped needles attached. Without moving items within the drawer, the surveyor was unable to view the tip of the other five visible syringes. R1's record included an untitled assessment document from a mental health services program dated January 4, 2023, which indicated the following: - R1's drug of choice was opiate; - R1 had been on methadone for three years;	01730			

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01730	Continued From page 47 - R1 started using heroin in 2005 and would use weekly however, it turned to daily; - R1 started to use Percocet in 2004 and would use daily; - R1 started to use cocaine at 18 years old and R1 would use once a weekend or once a month; - R1 reported they completed three years of back-to-back chemical dependency treatment from 2015 to 2018; - R1 had a risk of abuse to self with his substance use, with history of IV opiates, and most recent Fentanyl; and - R1 had suicidal ideation "all the time". R1's record included a letter from a mental health provider from an intensive residential treatment services program dated June 27, 2024, which indicated the following: - the prescriber believed R1 needed to be referred to a higher level of care due to recent disclosure of ongoing IV/IM opioid use over the last month; - R1 declined a medically supervised detoxification recommendation; and - R1 acknowledged the recommendations as well as the risks of declining the recommendations and intended to return to the licensee where they previously lived. R1's record included an After Visit Summary (AVS) dated December 24, 2024, indicating R1 was seen for substance abuse and acute brain disorder. R1's ongoing assessments dated September 30, 2025, January 6, 2026, and March 31, 2026, indicated the following: - R1 needed full medication management and setup; - R1 needed registered nurse (RN) consultation	01730			

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01730	Continued From page 48 to clarify instruction changes from medical providers; - the RN was responsible for monitoring medication supplies and reordering medication as needed; - R1 medications were stored in a lockable cabinet; - unlicensed personnel (ULP) were delegated oral, sublingual, and topical medications; and - ULP to contact nurse via phone or text if questions or concerns arise with medication management. R1's progress note dated April 22, 2026, indicated clinical nurse supervisor (CNS)-C reviewed R1's chart. The note read, "[R1] appears to be responding to internal stimuli. Usure (sic) if he used drugs. Per staff report, he is disoriented, irritable and agitated. I discussed with him to take the scheduled Haldol as prescribed. He is intermittently refusing Haldol and other medications at bedtime. Will continue to educate him (sic) importance of taking his prescribed medications. Will continue to monitor for safety." R1's Med Admin Summary -Actual - Month dated May 2026 included "Naloxone Hydrochloride [Narcan (opioid antagonist medication used to rapidly reverse the effects of opioid overdose)] As Needed Use 1 spray in a nostril. Call 911 if no response in 2 - 3 minutes. Repeat does (sic) in another nostril. Administration instructions:" The instructions lacked an indication for use. On May 4, 2026, at 10:53 a.m., owner (O)-A stated R1 had a history of drug use and went to treatment for a couple of months, however, R1 had still not stopped. The surveyor inquired if the licensee had Narcan in the facility. O-A stated they were unsure.	01730			

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01730	Continued From page 49 On May 4, 2026, at 10:55 a.m., the surveyor observed the licensee's locked medication cabinet and observed two boxes of Narcan 4 milligrams (mg) with expiration dates of December 4, 2025, and February 8, 2026. On May 4, 2026, at 2:10 p.m., ULP-B stated they knew how to use Narcan, and they were trained by CNS-C. On May 4, 2026, at 2:28 p.m., CNS-C stated R1 had a history of drug usage. CNS-C stated they reviewed the medication cabinet every three months for expired medications. CNS-C stated the licensee used pharmacy connect and they reordered medications through the system when they needed to be replaced or more medication was indicated. CNS-C stated R1's Narcan instructions in the medication administration record (MAR) did not include all of the instruction because they transcribed the order as the prescriber wrote it. CNS-C stated they had additional instructions located on the outside of the medication cabinet. CNS-C stated they did not know why the medication closet contained expired Narcan. CNS-C stated they believed the medication was not expired the last time they audited the medication cabinet. CNS-C then stated they had not checked the medication cabinet lately and they had not used the Narcan. CNS-C stated they were not aware of syringes in R1's room. CNS-C stated they knew there was a history of drug use, and R1 had an infection on the arm from injecting drugs, which they were monitoring. CNS-C stated they assess R1 when they see them, however, they did not conduct room searches nor had staff reported any drug use for R1.	01730			

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01730	Continued From page 50 R1's individualized medication management plan comprised of multiple documents including ongoing assessments lacked specific resident instructions relating to the administration of medications. In addition, the licensee failed to follow the individualized medication management plan by not reordering lifesaving medication Narcan timely. The licensee's Storage/Control of Medications policy dated December14, 2022, indicated as specified in the resident's medication management program, a licensed nurse would regularly set up medications in a clearly labeled container based on the resident's medication regimen. At this time, the nurse checks medication expiration dates and notes medications needing to be reordered. The licensee's Medication Supply policy dated December 14, 2022, indicated the medication management plan would identify who was responsible for monitoring medication supplies and ensure refills are ordered timely. Should medications not be obtained as needed, the RN would complete the following: - discuss the discrepancy with the resident and/or resident representative identified in the medication management plan; - coordinate with pharmacy to obtain/maintain a back-up supply of medications; - revise the medication management plan regarding who was responsible for assuring an adequate supply of medication for the resident. The licensee's Service Plan for Medication Management policy dated December 14, 2022, indicated the medication management plan would include identifications of person responsible for monitoring medication supplies and ensuring	01730			

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01730	Continued From page 51 refills are ordered/timely and would include any resident specific requirement related to documenting medications, verification that all medications were administered as prescribed and monitoring of medication use to prevention possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01730			
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document each medication administered by the assisted living facility staff or failed to document on why the medication administration was not completed as prescribed for one of three residents (R1). In addition, the licensee failed to document the effectiveness of an as needed medication (PRN) for one of three	01760			

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01760	Continued From page 52 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION ADMINISTRATION DOCUMENTATION NOT COMPLETED R1 was admitted to the licensee on February 3, 2023, and began receiving assisted living services. R1's diagnoses included schizophrenia (a mental health condition that affects how people think, feel and behave, often causing a loss of touch with reality), anxiety disorder, attention-deficit hyperactivity disorder (ADHD), nicotine dependence, and mood disorder. R1's Addendum to Contract - Waiver - MN signed February 25, 2025, indicated R1 received assistance with appointments, bathing reminders, dressing, transportation, grooming, housekeeping, behavior management including self-injurious behavior and orientation management, meals, medication administration, safety checks, shopping, socialization, and monitoring smoking. R1's Med Admin Summary - Actual - Month dated April 26, 2026, lacked documentation for the	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33981	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER A-A-H MERCY HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 3554 JUNE AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 53 following medication administrations: - amphetamine/dextroamphetamine 10 mg at 1:00 p.m. on April 6, 2026, and April 11, 2026; - amitriptyline hydrochloride 25 mg at 9:00 p.m. on April 11, 2026, and April 12, 2026; and - Haldol 5 mg on April 11, 2026, and April 12, 2026. EFFECTIVENESS R2 was admitted to the licensee on May 5, 2025, and began receiving assisted living services. R2's diagnoses included major depression, alcohol abuse with alcohol induced anxiety, and attention and concentration deficit. R2's Addendum to Contract -Waiver - MN dated May 15, 2025, indicated R2 received assistance with appointments, bathing, dressing, transportation, finance management, housekeeping, behavior management, meals reminder, medication administration, safety checks, shopping, and socialization. R2's Med Admin Summary - Month dated April 2026, indicated R2 received Trazodone 50 mg on April 5, 14, 15, and 28, 2026, before bed for sleep. The medication administration record (MAR) lacked documentation of the effectiveness of PRN medication. On May 5, 2026, at 1:06 p.m., clinical nurse supervisor (CNS)-C stated R1 declined medications or took the medication at different times than what was listed in the MAR. CNS-C stated they believed either R1 declined the medication or received the medication late on the dates listed above. CNS-C stated Residex (a documenting software program) did not allow unlicensed personnel (ULP) to document on	01760			

Minnesota Department of Health

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01760	Continued From page 54 medications if they were administered late and they would have to be notified in order to write a progress note in Residex that the medication was administered. CNS-C stated they had not received notifications from staff related to R1's medications, and they would provide additional training to ULP. CNS-C stated effectiveness of PRN medication should be documented on the MAR. CNS-C stated they have not received notifications from employees or an alert in Residex that R2 received trazodone. CNS-C stated the trazodone was used for sleep and the effectiveness should be documented on, so they would be able to update the prescriber with how the medication worked for R2. The licensee's Medication Documentation policy dated December 14, 2022, indicated each medication administered by the licensee's staff would be documented in the resident's clinical record. Documentation would be complete, accurate, and legible. If administration of one or more medications were not completed the staff would document the reason for why the medication was not administered. In addition, for PRN medications, documentation would include the reason for the medication and follow-up to determine effectiveness. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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	01890			

Minnesota Department of Health

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01890	Continued From page 55 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 discard expired medication for three of three residents (R1, 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: On May 4, 2026, at 10:55 a.m., the surveyor observed the the following expired medications in the licensee's medication cabinet: - trazodone 100 mg with an expiration date of August 5, 2025, for R3; - trazodone 100 mg with an expiration date of November 18, 2025, for R3; - trazodone 100 mg with an expiration date of November 5, 2025, for R3; - trazodone 100 mg with an expiration date of March 9, 2026, for R3; - ondansetron 8 mg with an expiration date of November 18, 2025, for R3; - two boxes of Narcan with an expiration date of December 4, 2025, and February 8, 2026, for R1; - two cards of hydroxyzine hydrochloride (hcl) 25	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33981	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/06/2026
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01890	Continued From page 56 mg with an expiration date of December 9, 2025, for R2; - ibuprofen 600 mg with an expiration date of December 9, 2025, for R2; - Tylenol 500 mg with an expiration date of December 9, 2025, for R2; and - fluoxetine capsule 20 mg with an expiration date of December 29, 2025, for R2. On May 4, 2026, at 2:28 p.m., clinical nurse supervisor (CNS)-C stated they reviewed the medication cabinet every three months for expired medications. CNS-C stated if an expired medication was observed they would remove the medication for disposal or return the medication to the pharmacy. CNS-C stated they completed a medication cabinet audit "not long ago" however, they believed the medication expired after their last audit. The licensee's Medication Administration policy dated December 14, 2022, indicated the licensed nurse was responsible for assessing medications to assure that all medications were current, ordered by the prescriber, and identified any expired or outdated medications, which would be disposed according to policy. The licensee's Disposition and Disposal of Medication policy dated December 14, 2022, indicated medications for a resident that were expired may be provided for disposal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Minnesota Department of Health

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02320	Continued From page 57	02320			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-G) followed appropriate medication administration procedures. 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: ULP-G was hired on May 20, 2024, to provide assisted living services. ULP-G's personnel file included a Home Health Aide Supervision Medication Management Competency evaluation dated May 2, 2024, which indicated the following: - ULP-G was found competent to administer oral medications;	02320			

Minnesota Department of Health

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02320	Continued From page 58 - ULP-G knew the 5 rights of medication administration; and - ULP-G was able to locate the correct medication administration record (MAR). On May 5, 2026, at 8:51 a.m., the surveyor observed ULP-G sanitize their hands, apply gloves, open the medication cabinet, remove R3's medication bin from the cabinet, and remove one benztropine 0.5 milligrams (mg) from the medication card to place into the medication cup. ULP-G then opened a preset medication packet that contained propranolol 20 mg and vitamin D3 1000 units (u) and placed the medication into the medication cup. ULP-G then opened the narcotic box in the medication cabinet, removed one tablet of lorazepam 1 mg from the card, placed it into the medication cup, and put the lorazepam back into the narcotic locked box. The surveyor did not observe ULP-G use a paper format or an electronic format MAR to verify the medications in the medication cup were the correct medications for R3. ULP-G then administered the medications to R3, went to the laptop, opened the electronic medication administration record (EMAR), hit complete at the bottom of the screen, and closed the laptop screen. The surveyor was unable to visualize the medication ULP-G documented on due to how briefly the screen was open. The surveyor requested ULP-G reopen the EMAR and had ULP-B show them what medications they documented on. At 8:55 a.m., the surveyor inquired how ULP-G knew they administered the correct medications to R3. ULP-G stated the medications were labeled for morning administration. The surveyor observed the prescription labels of each medication with ULP-G and observed not all medication cards were labeled with morning however, some were labeled to give the medication once or twice per	02320			

Minnesota Department of Health

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02320	Continued From page 59 day. The surveyor inquired how they completed the five rights of medication administration without use of the EMAR. ULP-G stated, "cause I know the patient". The surveyor inquired how ULP-G was trained to administer medications. ULP-G stated they were trained to provide the resident with the correct medication and were trained by owner (O)-A and clinical nurse supervisor (CNS)-C. ULP-G stated they were trained to use the EMAR to verify they provided the correct medications to the resident. The surveyor inquired why ULP-G did not use the EMAR when they administered the medications. ULP-G stated, "because I know what medication to give." O-A from across the room stated ULP-G might be scared. On May 5, 2026, at 1:04 p.m., CNS-C stated they trained ULP to compare medications to the EMAR by using the six rights of medication administration. CNS-C stated they complete a medication administration demonstration and then have the ULP return the demonstration of medication administration. CNS-C stated after the ULP are found competent to pass medications they completed a 30-day supervision on medication administration to ensure they are still administering medications correctly. CNS-C stated ULP were also trained to document the medication administration in the EMAR after medications were administered. The licensee's Medication Administration policy dated December 14, 2022, resident of the licensee's facility are entitled to a safe administration of medication by qualified personnel according to a written medication management plan. No further information was provided.	02320			

Minnesota Department of Health

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02320	Continued From page 60 TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



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

Page: 1

Establishment Info

AAH MERCY HOME HEALTH
3554 June Ave N
Robbinsdale, MN 55422
Hennepin County
Parcel:

Phone:

License Info

License: HFID 33981

Risk:
License:
Expires on:
CFPM: Abdi H Abdi
CFPM #: 122374; Exp: 03/01/2027

Inspection Info

Report Number: F1013261024
Inspection Type: Full - Single
Date: 5/5/2026 Time: 12:30 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery:

New Order: 3-500C Microbial Control: date marking

3-501.17B *Priority Level: Priority 2 CFP#: 23*

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPEN CONTAINER OF READY-TO-EAT COMMERCIALY PROCESSED HAM WITHOUT A DATE WAS LOCATED IN THE KITCHEN REFRIGERATOR. PER STAFF THE FOOD PACKAGE WAS OPENED THE DAY PRIOR. COMPLY WITH RULE. DISCUSSED DATE MARKING PROCEDURES AND STAFF DATE MARKED THE FOOD.

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

New Order: 4-200 Equipment Design and Construction

4-201.11GMN *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: LEFTOVER PIZZA PURCHASED BY THE STAFF AND SERVED ON THE DAY PRIOR WAS STORED IN THE KITCHEN REFRIGERATOR. THE FACILITY'S MENU LISTED LEFTOVERS AS A MEAL OPTION. COMPLY WITH RULE. DISCUSSED SAME DAY SERVICE REQUIREMENTS AND THE PIZZA WAS DISCARDED.

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

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: DUST AND DEBRIS WERE ON THE TEXTURED KITCHEN CEILING. GRIME BUILD UP WAS ON THE WALL ABOVE THE KITCHEN RANGE. COMPLY WITH RULE. DISCUSSED CLEANING PROCEDURES WITH STAFF.
Comply By: 5/5/2026 Originally Issued On: 5/5/2026

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator A. Crews.

The establishment has a residential kitchen. Food must be served on the same day it was prepared. The kitchen has wood cabinets, vinyl floor, wall papered walls, laminate counter top, and a textured painted ceiling.

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

Residential dish machine is available to wash ware. The dish machine should be run on the sanitize/high temperature cycle.

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

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

I acknowledge receipt of the Metro District Office inspection report number F1013261024 from 5/5/2026

Jerry Malloy

Abdi H Abdi
Operator

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info

AAH MERCY HOME HEALTH
Robbinsdale
County/Group: Hennepin County

Inspection Info

Report Number: F1013261024
Inspection Type: Full
Date: 5/5/2026
Time: 12:30 pm

Food Temperature: **Product/Item/Unit:** Ham; **Temperature Process:** Cold-Holding

Location: Kitchen Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding

Location: Kitchen 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

Page: 1

Establishment Info

AAH MERCY HOME HEALTH
Robbinsdale
County/Group: Hennepin County

Inspection Info

Report Number: F1013261024
Inspection Type: Full
Date: 5/5/2026
Time: 12:30 pm

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

Location: Kitchen **Equal To** 166 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL33981016-0	Date: 5/5/2026
Facility Name: AAH MERCY HOME HEALTH	
Facility Address: 3554 June Ave N, Minneapolis, Minnesota 55422	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

Comments: Both labeled exit doors were equipped with security chain locks. Operation of each chain required a key to release the lock before the door could be opened, creating a barrier to immediate egress. While the surveyor was on-site, the House Manager (HM) removed both security chains from the exit doors.

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

Comments: A plastic bucket was observed being used as an ashtray on the exterior rear patio. The presence of discarded smoking materials in a non-designated receptacle presents a potential fire hazard.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
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: House Manager (HM) tested the smoke alarms, and the alarms in the basement hallway, the office, and the upstairs hallway did not activate.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread**TIME PERIOD OF CORRECTION:** Seven (7) days

1. 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: The fire extinguisher located in the kitchen was rated 1-A:10-B:C, which did not meet the minimum required rating. The licensee provided a compliant 2-A:10-B:C fire extinguisher, which was located in the basement hallway.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread**TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

Comments: The surveyor observed water leaking from a pipe in the basement laundry room ceiling. The leak was dripping onto the windowsill and onto the laundry equipment below. This condition increases the potential electrical hazards involving the laundry equipment, and possible structural or equipment damage due to ongoing moisture exposure.

☒ **TAG IDENTIFICATION: 0810**

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

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

Comments: The FSEP 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.

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

Comments: The FSEP did not identify specific fire protection actions for residents. There was a section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The document was left blank where the licensee failed to fill in the requirements for residents.