Electronically Delivered

July 28, 2026

Licensee
Fortunate Homes LLC
6937 France Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL37185016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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:

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37185	A. BUILDING: _____ B. WING _____	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	6937 FRANCE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: SL37185016-0 On June 30, 2026, through July 2, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four resident(s); four receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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, Food and Beverage Establishment Inspection Report (FBEIR) dated June 30, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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.	0 680		

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0 680	Continued From page 4 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: The licensee's undated EPP lacked evidence of the following required content: - process for EPP collaboration; - roles under a waiver declared by secretary; - names and contact information; - emergency officials contact information; and - primary and alternate means for communication. On July 2, 2026, at 1:26 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-C confirmed the licensee's EPP was missing required contact information for the EPP that included local, tribal, regional, State, Federal emergency preparedness officials, staff, and residents' physicians. LALD/LPN-C acknowledged the licensee's EPP included a definition of 1135 waiver but did not include a policy and procedure that outlined the facility's role under a declared public health emergency. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements.	0 680		

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0 680	Continued From page 5 This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	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;	0 780		

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0 780	Continued From page 6 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a	0 790		

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0 790	Continued From page 7 minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: from PEIR for the related violation]. Level 2 Widespread F 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 June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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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 repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota 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 June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 800		

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

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0 810	Continued From page 10 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 June 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01760 SS=F	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	01760		

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01760	Continued From page 11 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the license failed to ensure medication administration was documented accurately for one of one resident (R1) who had medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2026, at 8:32 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. The surveyor did not observe ULP-A assist R1 with the administration of fluticasone propionate 50 microgram (mcg) nasal spray (commonly known as Flonase) but ULP-A was observed to document the administration of the fluticasone propionate 50 mcg nasal spray following the administration of medications. The surveyor observed ULP-A assist with medication administration for fluticasone propionate/salmeterol 100/50 mcg inhalation powder (commonly known as Advair) but ULP-A documented R1 received Wixela Inhub 500/50 mcg inhaler one puff by mouth twice a day (which	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37185	A. BUILDING: _____ B. WING _____	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	6937 FRANCE AVENUE NORTH BROOKLYN CENTER, MN 55429

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01760	Continued From page 12 is the equivalent generic for Advair). R1 was admitted to licensee on November 1, 2022, with a diagnosis of paraplegia. R1's Service Plan (Waiver) - Addendum to Contract dated July 1, 2026, indicated R1 received assistance with medication administration. R1's Interagency Transfer Orders dated June 25, 2026, indicated R1 was to receive fluticasone propionate 50 mcg nasal spray each nostril daily and fluticasone propionate/salmeterol 500/50 mcg inhalation powder one puff twice a day. R1's Med Admin Summary - Actual - Month (MAR) dated July 2026, indicated R1 had received fluticasone propionate 50 mcg nasal spray (commonly known as Flonase) on July 1, 2026, at 9:21 a.m., but this was not administered to R1. Also, R1's MAR indicated R1 had received wixela inhub 500/50 mcg inhaler on July 1, 2026, at 9:22 a.m., but R1 had received fluticasone propionate/salmeterol 100/50 mcg inhalation powder which was not the same medication or dosage. R1's MAR excluded fluticasone propionate/salmeterol 100/50 mcg inhalation powder (commonly known as Advair). On July 1, 2026, at 10:15 a.m., ULP-A confirmed they did not give R1 their fluticasone propionate 50 mcg nasal spray for medication administration. R1 stated the fluticasone propionate 50 mcg nasal spray was the same as R1's purple inhaler (the purple inhaler was in reference to fluticasone propionate/salmeterol). On July 1, 2026, at 3:21 p.m., registered nurse (RN)-F stated every time R1 goes to hospital, she	01760		

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01760	Continued From page 13 is discharged back to the facility with fluticasone propionate/salmeterol and not Wixela Inhub. RN-F stated R1 preferred use to the fluticasone propionate/salmeterol since the resident had to pay for this medication. RN-F stated in the past R1's medical provider has declined to order this medication since R1's insurance did not cover the fluticasone propionate/salmeterol. RN-F stated R1 only liked to have the fluticasone propionate 50 mcg nasal spray on certain days but R1 still wanted to have the medication as scheduled daily instead of an as needed medication. RN-F stated the expectation is for staff to document on medications given, refused or the reason why a medication was not administered. RN-F stated fluticasone propionate/salmeterol 500/50 mcg inhalation powder should have been transcribed from the hospital Interagency Transfer Orders dated June 25, 2026, so the ULPs could accurately document the actual medication and dosage being administered. The licensee's Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated the licensee would create and maintain a correct and accurate medication record for each resident who received medication assistance or administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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02310	Continued From page 14 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R1, R2) with bed rails. 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: R1 On June 30, 2026, at 12:07 p.m., during a facility tour, the surveyor observed R1 had a hospital style bed with bilateral upper side rails. The left-side rail was grabbed by the surveyor and was noted to be loose. The right-side rail was up against the wall. R1 was admitted to licensee on November 1, 2022, with a diagnosis of paraplegia. R1's Service Plan (Waiver) - Addendum to Contract dated July 1, 2026, indicated R1 received assistance with medication administration.	02310		

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02310	Continued From page 15 R1's Bed Safety Assessment dated April 25, 2026, indicated R1 used the side rails to assist with bed mobility and repositioning. The assessment lacked documentation of measurements for zone four of entrapment. R1's progress notes dated June 20, 2026, at 4:39 p.m., documented by registered nurse (RN)-F, Read the following, "Client's bed rails were reported as loose and not functioning properly. RN assessed client's bed rails and confirmed they are loose and not functioning safely. Maintenance slip completed. RN contacted [company name] DME (durable medical equipment) multiple times for repair or replacement; DME reports the request must go through insurance. RN called the client's insurance, who stated they cannot assist because the client is on a CADI waiver and bed repairs are covered through the waiver. RN contacted the contracted case manager, who stated they cannot assist while the client is admitted to the hospital and will follow up once she returns. RN also reached out to [company] for a donated hospital bed; none available at this time. RN will continue to follow up. Client is currently admitted to the hospital. She is alert, oriented, and able to direct her own cares. Staff have been updated and will continue safety checks and monitoring as we await resolution of the bed situation. RN will continue to support the client and reassess needs upon their return." R1's Maintenance Request dated June 20, 2026, indicated R1's side rail was found to be loose and not functioning as it should; and on June 22, 2026, the maintenance staff wrote a follow up note on the request that indicated RN verified on visit, cannot fix bed and call DME to replace. The documentation did not indicate the side rail was	02310		

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02310	Continued From page 16 tightened or corrected to be safe. R1's record lacked further documentation regarding R1's loose side rails after June 20, 2026, and further assessment of the safety of the side rails after R1 returned to the facility from the hospital on June 25, 2026. R2 On June 30, 2026, at 12:07 p.m., during a facility tour, the surveyor observed R2 had a hospital style bed with bilateral upper side rails. The left-side rail was grabbed by R2 and was noted to be very loose. The right-side rail was up against the wall. R2 stated to the surveyor that the side rail used to not be loose when they had first arrived at the facility in December 2025, but they were working on getting a new bariatric hospital bed. R2 stated the bedrail was loose due to their weight and the need to use the side rail to reposition and turn in bed. R2 stated the current hospital bed had a recall and was not supposed to be used but it had been delivered to the facility prior to R2 moving in. R2 stated they had received a letter in May 2026, that indicated the hospital bed had a recall. R2 was admitted to the licensee on December 26, 2025, with a diagnosis of morbid (severe) obesity, muscle weakness, and sleep terrors. R2's Service Plan (Waiver) - Addendum to Contract dated December 26, 2025, indicated R2 received assistance with medication administration. R2's Bed Safety Assessment dated April 25, 2026, indicated R1 used the side rails to assist with bed mobility and repositioning.	02310		

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02310	Continued From page 17 R2's Medline Industries, LP Immediate Action Required Urgent Medical Device Recall dated May 15, 2026, indicated field correction instructions related to Medline Basic Homecare Beds to immediately inspect all impacted beds, and, if any of the following is identified, immediately unplug the bed and contact Medline for a replacement pendant: - visible damage to the pendant; - the pendant cords are damaged or fraying or internal wires are exposed; - the pendant buttons do not work or are stuck; - the pendant has liquid damage; and - the pendant becomes warm or hot to the touch. On June 30, 2026, at 2:17 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-C stated the licensee had a maintenance slip last week for R1 or R2's side rails but could not recall which resident. LALD/LPN-C stated they knew R2's doctor and R2's county case manager had been trying to get a bigger bed for R2 but had issues with R2's insurance covering the bed cost. On June 30, 2026, at 2:19 p.m., clinical nurse supervisor (CNS)-D stated R2's bed was not recalled and R2's bed was the bed the doctor had ordered due to R2 not qualifying for a bariatric bed. CNS-D stated they were not aware of a recall on R2's bed as the last time they had checked, it was not on the recall list. On July 1, 2026, at 11:16 a.m., R2 confirmed the side rails were not recalled, but the bed was recalled due to a fire hazard with the remote or motor having the potential to overheat. R2 stated a different facility where they had resided previously had been told not to order the bed, but they had ordered it anyways; and they had the	02310		

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02310	Continued From page 18 bed delivered to the current facility just prior to when R2 moved into the current facility. R2 stated CNS-D had been working on getting a new bed, however his case manager for his waiver had been on vacation for two months and the person who had been covering for them did nothing. R2 stated they had given the recall letter to CNS-D. On July 1, 2026, at 11:40 a.m., CNS-D stated they did not receive a recall letter for R2's bed. CNS-D stated they had discussions with getting bariatric bed for R2 during case conferences with R2's case manager and family. On July 1, 2026, at 12:41 p.m., LALD/LPN-C stated they had a recent care conference with R2 but there was no mention of a bed recall. LALD/LPN-C stated R2's equipment (including hospital bed) had been ordered by the previous facility. LALD/LPN-D stated R2 was alert and orientated; and R2 would know about his bed needs as they always verbalized their needs. LALD/LPN-C stated all they knew was that R2 was in the process of getting a bariatric bed with their insurance. On July 1, 2026, at 1:18 p.m. RN-F stated they had received a paper from R2 with some bed information so they had faxed it but could not recall more information. RN-F stated they had assessed R1's side rails on June 20, 2026, and placed a maintenance slip to have the side rails fixed. RN-F stated they had called the DME company several times but was told the DME company had placed a ticket and would call the facility. RN-F stated the DME company also told them before sending out a technician, they would need to check with R1's insurance to see if they could get a new bed.	02310		

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02310	Continued From page 19 On July 1, 2026, the surveyor spoke to Medline representative (MR)-G in the recall department regarding R2's hospital bed to determine if a recall had been issued and if there was a notice that had been sent out, MR-G confirmed they had sent out a letter to customers and stated Medline had used the word "recall" since the company had instructions for the customer to take action, however the hospital bed could be used as normal. MR-G stated they had reports of people storing boxes under the bed or hanging the remote which can cause stress and potential risk. MR-G stated if the remote got stuck or needed to be replaced, it was due to user error. On July 1, 2026, at 2:25 p.m., CNS-D confirmed the last assessment completed on R1's hospital bed and side rails was on April 25, 2026. CNS-D stated they did not assess the side rails when R1 had returned home from the hospital on June 25, 2026, as they were more focused on R1's change in condition. RN-F stated they had been talking to the DME company every day however they only documented their initial note in R1's record and the maintenance slip for the facility. RN-F stated they did not have the name of a person they talked to with the DME company as they only talked to the person who would answer the phone in customer service each time for an update. On July 2, 2026, at 12:16 p.m., the surveyor observed the remote for R1's hospital bed. The remote and cords did not have any noticeable damage. R1 denied the remote ever having liquid damage to their knowledge. R1 stated the remote has been warm to the touch on and off at times since they have been using the bed. R1 stated the remote seemed to have a delay when they pushed the button to raise the foot of the bed. R1 showed the surveyor by pushing the button to	02310		

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02310	Continued From page 20 lower the foot of the bed. The surveyor observed the foot of the bed being lowered as they pushed the button. Then R2 pushed the button to raise the foot of the bed, however the surveyor did not see it move right away and had a delay before the foot of the bed came up. R1 showed the surveyor there was no delay when they pushed the button to raise or lower the head of the bed. The licensee's Side Rails policy dated August 1, 2021, indicated licensee would assess the use of side rails, educate the resident and/or responsible person regarding the risks and benefits of side rails, verify the side rail in use was of safe design, and utilized consistent with the manufacturer's directions. The policy also indicated the side rail design would be consistent with FDA's 2006 recommended dimensional measurements to reduce entrapment. The FDA's A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked	02310		

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02310	Continued From page 21 Questions (FAQs) website read under hospital-style bed rails licensee should ensure, "measurements were completed and documented, the rails were FDA compliant, and the risk versus benefits were discussed and documented with the resident/responsible party." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

Fortunate Homes LLC
6937 FRANCE AVENUE NORTH
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37185

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

Inspection Info

Report Number: F1062261139
Inspection Type: Full - Single
Date: 6/30/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT: OBSERVED DESIGNATED HANDWASHING SINK BASIN FULL OF DISHES DURING INSPECTION. COMPLY WITH RULE ABOVE.
Comply By: 6/30/2026 Originally Issued On: 6/30/2026

Food & Beverage General Comment

INSPECTION COMPLETED ON BEHALF OF RHAWNIE QUINEHAN (HRD).

2 BASIN SINK WITH 1 SIDE DESIGNATED FOR HANDWASHING, WOOD FLOORS, DRYWALL, LAMINATE COUNTERS.

DISCUSSED PROHIBITIONS ON SERVING RAW OR UNDERCOOKED FOOD, HAND SINK RESITRCTIONS, ILLNESS RECORDING, AND HOT WATER SANITIZER TESTING.

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 F1062261139 from 6/30/2026

NELSON KANYI WANJAU
CFPM

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Fortunate Homes LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1062261139
Inspection Type: Full
Date: 6/30/2026
Time: 11:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CREAM CHEESE **; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Fortunate Homes LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1062261139
Inspection Type: Full
Date: 6/30/2026
Time: 11:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37185016-0	**Date:** June 30, 2026
Facility Name: Fortunate Homes LLC	
Facility Address: 6937 France Ave N, Brooklyn Park, MN 55429	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Isolated **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: The smoke alarm in the lower level hallway was not interconnected and only sounded locally.

☒ **TAG IDENTIFICATION: 0790**

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

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

   Comments: The fire extinguisher in the lower level living room was installed 68 inches above the finished floor. The fire extinguisher in the kitchen was installed 73 inches above the finished floor.

   Fire extinguishers shall be installed no higher than 60 inches above the finished floor.

   The fire extinguisher in the lower level living room lacked documentation of annual service. Licensed assisted living director (LALD)-E stated that their contractor had forgotten to service the fire extinguisher in the living room.

☒ **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 wall inside of resident room 1 was damaged near the door.

   The first floor bathroom ceiling had peeling paint.

   Above the side door to the driveway the soffit and fascia had peeling paint and bare exposed wood.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: Staff training records were requested at 12:45 p.m. At 1:00 p.m. LALD-E provided what they stated were staff training records on a drill evaluation form. The form lacked a date, staff member names, or any reference of training taking place. The surveyor confirmed two separate times that the documents that LALD-E provided were their only records for staff training.

   When the surveyor exited with the facility at 1:54 p.m. and explained that the facility would be receiving a tag for failure to provide staff training, LALD-E stated that they had staff training records in the employee files. LALD-E provided the surveyor with different staff training records after the surveyor had already exited with the facility.

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

   Comments: LALD-E provided drill documentation that had the last date of September 5, 2025. LALD-E stated that all the drills were recorded using a third party reporting software, but that no one at the facility had access to "run the report" to provide the surveyor with current fire drill records. No documentation of current fire drills was provided for review.