Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

May 28, 2026

Licensee
Bright Home ALC
6512 Indiana Ave North
Brooklyn Center, MN 55429

RE: Provisional Conditional License Number 420125
Health Facility Identification Number (HFID) 41548
Project Number(s) SL41548015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 9, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 27, 2026**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $500.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Bright Home ALC a conditional provisional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Bright Home ALC is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations

begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. No new admissions: Bright Home ALC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Bright Home ALC must provide the Department:

i. A list of the names and birthdates of any individuals Bright Home ALC is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents including:
   1. Name and birthdate of each resident
   2. Current payment source for services
   3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
   4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Bright Home ALC to correct the violations cited during the survey as well as to determine the overall practice of Bright Home ALC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

d. Follow-up survey: At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.

e. Corrective Action Plan: Bright Home ALC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Bright Home ALC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines Bright Home ALC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Bright Home ALC. If MDH determines Bright Home ALC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Renee L. Anderson directly at: 651-201-5871 or email at: Renee.L.Anderson@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41548	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT HOME ALC	6512 INDIANA AVE N BROOKLYN CENTER, MN 55429

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL41548015-0 On April 6, 2026, through April 9, 2026, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction order is issued. At the time of the survey, there was one (1) resident receiving services under the provider's Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD), licensed by the Board of Executives for Long Term Services and Supports (BELTSS). 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held a Provisional Assisted Living Facility license effective on March 7, 2025. On April 6, 2026, at 12:11 p.m., during the entrance conference, administrator (A)-A stated LALD-D was the current LALD for the licensee; however, he would not be able to be reached by phone during the survey due to currently being out of the country. On April 6, 2026, at 1:00 p.m., during a	0 110		

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0 110	Continued From page 2 self-guided facility tour, the surveyor observed the licensee's wall, an area designated for postings, and noted a 14-day notice to residents and their families dated and signed on March 13, 2026, by LALD-D, which stated LALD-D's last working day with licensee would be March 30, 2026. On April 6, 2026, at 1:22 p.m., A-A and clinical nurse supervisor (CNS)-B stated they were unaware LALD-D had posted a 14-day notice of termination of employment; however, they had already started the process of hiring a new LALD, but all the paperwork for onboarding had not been completed yet. On April 6, 2026, at approximately 1:25 p.m., the BELTSS website indicated LALD-D had been the director of record for the facility, from January 1, 2026, to March 30, 2026. No other LALD was recorded with BELTSS as director of record for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 470		

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0 470	Continued From page 3 (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the daily staffing schedule was posted, at the beginning of each work shift, in a central location, accessible to staff, residents, volunteers, and the public, as required, potentially affecting all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a posted daily staffing	0 470		

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0 470	Continued From page 4 schedule including: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff members' resident assignments or work location; and - be posted, after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On April 6, 2026, at 1:00 p.m., during a self-guided facility tour, no posted staffing schedule was observed in any area of the facility. On April 6, 2026, at 1:18 p.m., clinical nurse supervisor (CNS)-B accompanied surveyor to the area within the facility where the staffing schedule was usually posted. Upon arrival, CNS-B stated, "it used to be right here, but I don't see it." On April 6, 2026, at 1:20 p.m., administrator (A)-A stated he was working on making a new staffing schedule. 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:	0 480		

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0 480	Continued From page 5 (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 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	0 480		

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0 480	Continued From page 6 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) 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, Food and Beverage Establishment Inspection Report (FBEIR) dated April 6, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 7 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the grievance procedure to include the name, telephone number, and e-mail contact information for the individual(s) who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the licensee's current 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) and was issued at a	0 550		

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0 550	Continued From page 8 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 6, 2026, at 1:00 p.m., during a self-guided facility tour, the surveyor observed the licensee's wall, an area designated for postings. The wall lacked the required posting for grievance procedures with the required content, contact information for the state OOLTC and the OMHDD, and information for reporting suspected maltreatment to MAARC. On April 6, 2026, at 1:30 p.m., administrator (A)-A stated the required content noted above was not posted. A-A further stated the postings may have been taken down by the previous licensed assisted living director (LALD)-D and replaced with LALD-D's resignation notice. The licensee's undated Complaint and Investigation Process policy indicated residents were provided with written information about how to address their concerns and questions related to their cares. The policy lacked a statement that the grievance procedure would be posted in a conspicuous place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be	0 690		

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0 690	Continued From page 9 current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's service plan dated February 15, 2026, indicated R1 received services which included assistance with medication reminders and medication administration by the registered nurse (RN) or unlicensed personnel (ULP) as prescribed, exercise and treatment reminders, blood sugar monitoring, dressing, grooming, toileting, bathing, oral hygiene, hair care, and eating assistance, housekeeping and laundry services. R1's medication administration record (MAR) dated April 2026, indicated staff assisted R1 with medication administration two times daily and as needed. The MAR included staff initials for medication administration that appeared to be those of administrator (A)-A, clinical nurse	0 690		

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0 690	Continued From page 10 supervisor (CNS)-B, and ULP-C. The documentation lacked authentication for A-A, CNS-B, and ULP-C, with the full name and title of the person who documented in R1's record. On April 9, 2026, at 11:10 a.m., during a telephone conversation, CNS-B stated licensee lacked documentation of the full name and title of the person who documented in R1's record. CNS-B further stated she was not aware of the requirement. Moreover, CNS-B stated licensee was planning to convert to an electronic medication administration system which would assist in ensuring all the required documentation would be included in the medical record. The licensee's undated Documentation of Medication Administration policy indicated each medication administered by the assisted living facility would be documented in the resident record. Furthermore, the documentation would include the signature and title of the person who administered the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
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;	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41548	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT HOME ALC	6512 INDIANA AVE N BROOKLYN CENTER, MN 55429

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0 810	Continued From page 11 (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 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 810		

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0 810	Continued From page 12 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints,	01470		

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01470	Continued From page 13 including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview, and record review, the	01470		

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01470	Continued From page 14 licensee failed to provide orientation to assisted living licensing requirements and regulations as outlined in MN statute 144G.63, Subd. 2, prior to providing services for three of three employees (administrator (A)-A, clinical nurse supervisor (CNS)-B, and unlicensed personnel (ULP)-C). 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: A-A A-A was hired December 31, 2025, to provide direct care services to the residents of the facility. A-A's online training transcript dated January 20, 2026, indicated A-A completed orientation training on January 13, 2026, for the following topics: - Overview of Assisted Living statutes; - Handling emergencies and using emergency services; - Handing of resident complaints, reporting of complaints, where to report; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery. A-A's employee record lacked orientation training for the following topics: - Review of provider's policies and procedures;	01470		

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01470	Continued From page 15 and - Consumer advocacy services. Documentation of services for R1 dated January 2026, indicated A-A assisted R1 with services January 1-7, 2026, prior to A-A completing orientation to Assisting Living. CNS-B CNS-B was hired December 31, 2025, to provide supervisory and direct care services to the residents of the facility. CNS-B's transcript dated January 20, 2026, indicated CNS-B completed orientation on January 12, 2026, for the following topics: - Overview of Assisted Living statutes; - Handling emergencies and using emergency services; - Handing of resident complaints, reporting of complaints, where to report; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery. CNS-B's employee record lacked orientation training on the following topics: - Review of provider's policies and procedures; and - Consumer advocacy services. An admission assessment for R1, dated December 31, 2025, indicated the assessment was completed by CNS-B, in person, on December 31, 2025, prior to CNS-B completing the required orientation to Assisted Living. Documentation of services for R1 dated January	01470		

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01470	Continued From page 16 2026, indicated CNS-B assisted R1 with services January 1-4, 2026, prior to completing the required orientation to Assisted Living. ULP-C ULP-C was hired on January 2, 2026, to provide direct care services to the residents of the facility. ULP-C's transcript dated January 20, 2026, indicated ULP-C completed orientation training on January 13, 2026, for the following topics: - Overview of Assisted Living statutes; - Handling emergencies and using emergency services; - Handing of resident complaints, reporting of complaints, where to report; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery. ULP-C's employee record lacked orientation training for the following topics: - Review of provider's policies and procedures; and - Consumer advocacy services. Documentation of services for R1 dated January 2026, indicated ULP-C assisted R1 with services January 10-12, 2026, prior to ULP-C completing orientation to Assisting Living. On April 7, 2026, at 3:57 p.m., CNS-B stated via email that between December 31, 2025, and January 6, 2026, A-A and CNS-B provided cares for R1. On April 7, 2026, at 4:52 p.m., CNS-B stated via telephone conversation that licensee had	01470		

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01470	Continued From page 17 assigned orientation training to the staff; however, had not followed up to ensure the training was completed prior to providing services to R1. Moreover, CNS-B was unaware of the training requirements for orientation. The licensees undated Facility Employee Orientation policy indicated all employees of the assisted living facility, including those who provide direct care, supervision of direct care, or management of services for the facility, would complete an orientation on topics required by Minnesota statutes and rules for assisted living. The policy does not indicate orientation would be conducted prior to providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup by the registered nurse (RN) included all the required content for one of one resident (R1). This practice resulted in a level two violation (a	01770		

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	41548	A. BUILDING: _____ B. WING _____	04/09/2026

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01770	Continued From page 18 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 6, 2026, at 12:11 p.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated that the licensee provided medication management services which included weekly medication setup by the registered nurse (RN). R1's individualized medication management plan dated December 31, 2025, indicated facility nurse would setup R1's medications weekly, and that the tasks delegated to unlicensed personnel (ULP) would include administering oral medications. On April 9, 2026, at 8:17 a.m., the surveyor observed ULP-C assisting R1 with medication administration. ULP-C retrieved R1's pill organizer from a locked cabinet, placed five pills into a medicine cup, and handed the medicine cup to R1. R1 took the medicine cup and poured the pills into his mouth and swallowed them with a drink. ULP-C placed her initials on the medication administration record (MAR) for each oral medication listed for the 8:00 a.m. scheduled administration time. R1's services documentation for April 2026, titled, "ACTIVITY DOCUMENTATION," included boxes to check for completion of tasks, including but not limited to cleaning, laundry, dressing reminders,	01770		

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01770	Continued From page 19 behavior monitoring and safety checks. The services documentation also included the task, "Medication set up by RN weekly." The box indicating April 4, 2026, was documented as completed with the initials of CNS-B. R1's record lacked documentation of medication setup to include the following: - name of medication; - quantity of dose; - times to be administered; - route of administration; and - name of person completing medication setup. On April 9, 2026, at 11:10 a.m., during a telephone conversation, CNS-B stated she had initialed the MAR after medication setup; however, lacked documentation of the full name of the person completing medication setup. CNS-B further stated she was not aware of the requirement. Moreover, CNS-B stated licensee was planning to convert to an electronic medication administration documentation system which would assist in ensuring all the required documentation would be included in the medical record. The licensee's undated Medication Setup policy indicated the facility nurse would setup medications for residents as ordered by the physician/prescriber, and medications would be setup using a weekly med-planner or computerized dispensing system with verbal reminder capabilities. Furthermore, facility staff setting up medications would follow accepted standards of practice. Moreover, the nurse would clearly document what nursing tasks were performed, what was assessed, and the findings. No further information was provided.	01770		

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01770	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Bright Home Alc
6512 Indiana Ave N

Brooklyn Center, MN 55418
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41548

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

Inspection Info

Report Number: F1051261083
Inspection Type: Full - Single
Date: 4/6/2026 Time: 1:00:00 PM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT:
AT THE TIME OF INSPECTION, THERE IS NO CERTIFIED FOOD PROTECTION MANAGER. BIRHAN WILL NEED TO RETAKE A FOOD SAFETY TRAINING CLASS. ONCE HE HAS PASSED THE FOOD SAFETY TRAINING CLASS, HE WILL NEED TO SUBMIT THOSE RESULTS TO MDH'S ONLINE CERTIFIED FOOD PROTECTION MANAGER APPLICATION. FACT SHEETS AND LINKS TO GET STARTED WILL BE PROVIDED WITH REPORT VIA EMAIL.
Comply By: 4/30/2026 Originally Issued On: 4/6/2026

New Order: 3-500C Microbial Control: date marking
3-501.17A *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.
COMMENT:
AT THE TIME OF INSPECTION, THE OPENED BAG OF HOT DOGS BOUGHT ON APRIL 3RD, 2026, WAS NOT DATE MARKED.
Comply By: 4/6/2026 Originally Issued On: 4/6/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT:
PROVIDE A THERMOMETER FOR THE KITCHEN UPRIGHT COOLER.
Comply By: 4/10/2026 Originally Issued On: 4/6/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT:
AT THE TIME OF INSPECTION, THERE IS NO HANDWASHING SIGN FOR EMPLOYEES IN THE MAIN FLOOR RESTROOM'S HANDWASHING SINK.
Comply By: 4/6/2026 Originally Issued On: 4/6/2026

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, RHONDA MAKELA.

DISCUSSED THE FOLLOWING WITH THE MANAGER, BIRHAN:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS
CERTIFIED FOOD PROTECTION MANAGER
DATE MARKING & DISPOSITION OF TCS FOOD

THE KITCHEN HAS LUXURY VINYL PLANK FLOORS, STONE COUNTERTOPS WITH HOLLOW BASES, LAMINATE CABINETS, ORANGE PEEL TEXTURE CEILING, AND A HIGH TEMPERATURE DISHWASHER.

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 St Cloud District Office inspection report number F1051261083 from 4/6/2026

Kai Yang

Birhan Asfaw
Manager

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Bright Home Alc
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1051261083
Inspection Type: Full
Date: 4/6/2026
Time: 1:00:00 PM

Food Temperature: Product/Item/Unit: HOT DOGS**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: KITCHEN
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41548015-0	**Date:** 4/9/2026
Facility Name: BRIGHT HOME ALC	
Facility Address: 6512 INDIANA AVE N BROOKLYN CENTER MN 55429	

☒ **TAG IDENTIFICATION: 0810**

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

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (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 provided FSEP was from a third-party provider and had not been updated to the specific facility.

2. 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: The licensee stated that staff training was done by a third party online platform and not on the licensee's written FSEP.