Electronically Delivered

March 11, 2026

Licensee
First Mercy Homes LLC
7420 17th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL36983016

Dear Licensee:

On February 17, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 11, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 11, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 11, 2025, found not corrected at the time of the February 17, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00

The details of the violations noted at the time of this follow-up survey completed on February 17, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Rhylee Gilb at 218-232-8285.

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

Sincerely,

Rhylee Gilb, Supervisor
State Rapid Response Team
Email: Rhylee.Gilb@state.mn.us
Telephone: 218-232-8285 Fax: 1-800-337-9238

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36983	A. BUILDING: _____ B. WING _____	R 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

(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 On February 17, 2026, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for survey SL36983016-1 The following correction orders are re-issued for SL36983016-1, tag identification 780, 800.	{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:	{0 480}	Not reviewed during this survey.	
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}		

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{0 650}	Continued From page 3 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}		

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{0 780}	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview, observation, document review the licensee failed to ensure smoke alarms were interconnected, as required. This affected all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: A physical environment inspection report dated December 9, 2025, indicated the licensee was ordered to correct the failure of no interconnected smoke alarms in seven days. The licensee received the licensing order violation on February 5, 2026. During an on-site observation on February 17, 2026, at 11:15 a.m., two sleeping units were noted in the basement of the facility that each had an independently operating smoke alarm. The alarms were not interconnected to each other, or to the smoke detector located in the laundry room near the sleeping units. There were no other smoke alarms located in the basement. It was observed the facility had two sleeping units upstairs that each had operating smoke alarms that were interconnected to each other as well as	{0 780}		

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{0 780}	Continued From page 5 a smoke alarm in the hallway shared by the two sleeping units. There were no smoke alarms observed in the facility kitchen or office. The smoke alarms upstairs were not interconnected to the smoke alarms in the basement. There was no smoke alarm located in the facility kitchen, despite a bracket to hold a smoke alarm observed near the kitchen doorway. There was no smoke alarm observed in the facility office located in the basement near two sleeping units. During an interview on March 3, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A stated repairs had been underway at the facility since September and could not be fixed overnight. LALD-A stated she contacted a fire company. An email from LALD-A dated Wednesday, March 4, 2026, at 4:37 p.m., indicated there was an invoice for interconnecting the fire alarms and were being installed tomorrow (March 5, 2026) and finished by Friday. An estimate invoice dated March 4, 2026, indicated estimate details to install whole home surge protection, interconnected smoke alarm system, arc fault protection for smoke alarm system, and junction box and light for downstairs bedroom. There was no completion date indicated on the invoice. The licensee-provided policy titled Fire Safety, dated January 23, 2023, indicated interconnected smoke alarms are in each occupied/sleeping room, outside each occupied/sleeping room and on each floor, including the basement, in accordance with the National Fire Protection Association Standard 72. The policy indicated that the administrator is responsible for regularly	{0 780}		

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{0 780}	Continued From page 6 (at least semi-annually) inspecting the smoke detectors and assuring that they are operational. The policy indicated the environment will be maintained in good repair and operation, including walls, floors, ceilings, systems and equipment regarding the health, safety, comfort and well-being of the residents.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on interview, observation and document review the licensee failed to keep the facility in a state of good repair. The facility failed to ensure all floor, doors, and ceilings are kept in a state of good repair as required. The facility failed to ensure the fire safety system and heating and cooling systems were kept in a good state of repair. 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	{0 800}		

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{0 800}	Continued From page 7 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an on-site observation on February 17, 2026, at 9:12 a.m., black colored marks were observed along baseboards and lower walls throughout the facility. Multiple areas of unfinished drywall damage repairs were observed throughout the facility, including hallways, stairwells, and other common living areas of the facility. During observation of an occupied sleeping unit in the basement, located above the resident's bed, there was no vent cover in place, and it was covered with a decorative metal sign placed by the resident. During an interview on March 3, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A stated repairs had been underway at the facility since September and could not be fixed overnight. An email from LALD-A dated Tuesday March 4, 2026, at 4:37 p.m., indicated the facility had possession of invoices for repairs completed at the facility. A document titled "[Name] Invoice Sheet for First Mercy Homes", signed by LALD-A and an unknown individual, on February 28, 2026, indicated a bedroom and office door were repaired February 2, 2026. The document indicated drywall repair was completed on February 3, 2026, February 4, 2026, February 7, 2026, and February 10, 2026. The document indicated wall painting was completed February 23, 2026.	{0 800}		

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{0 800}	Continued From page 8 The licensee-provided policy titled Fire Safety, dated January 23, 2023, indicated interconnected smoke alarms are in each occupied/sleeping room, outside each occupied/sleeping room and on each floor, including the basement, in accordance with the National Fire Protection Association Standard 72. The policy indicated that the administrator is responsible for regularly (at least semi-annually) inspecting the smoke detectors and assuring that they are operational. The policy indicated the environment will be maintained in good repair and operation, including walls, floors, ceilings, systems and equipment regarding the health, safety, comfort and well-being of the residents.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	{0 810}		

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{0 810}	Continued From page 9 (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:	{0 810}	Not reviewed during this survey.	
{01060} SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	{01060}		

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{01060}	Continued From page 10 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.	
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems	{01440}		

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{01440}	Continued From page 11 and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}	Not reviewed during this survey.	
{01530} SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	{01530}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01530}	Continued From page 12 (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.	
{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 resident's needs and according to an up-to-date service plan subject to accepted health care standards.	{02310}		

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{02310}	Continued From page 13 This MN Requirement is not met as evidenced by:	{02310}	Not reviewed during this survey.	

Electronically Delivered

February 5, 2026

Licensee
First Mercy Homes LLC
7420 17th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL36983016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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:

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - 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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36983	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	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: SL36983016-0 On December 8, 2025, through December 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; all 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) 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 December 9, 2025, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 650		

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0 650	Continued From page 4 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: On December 8, 2025, at 10:35 a.m., during the entrance conference, CNS-B stated employee records were kept both electronically and on paper and were available at the facility. CNS-B was hired on July 23, 2024, to provide supervision and oversite to unlicensed personnel and to provide direct care services to the licensee's residents. CNS-B's employee record lacked documentation of: -a current job description -annual performance review On December 11, 2025, at 3:40 p.m., CNS-B stated the licensee would ensure employee records were always complete. CNS-B stated the licensee planned to complete monthly audits to confirm this practice. The First Mercy Homes Assisted Living License policy, dated August 1, 2025, indicated the licensee would keep an employee record for all paid employees, and records would be kept up-to-date and confidential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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

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0 780	Continued From page 6 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 December 9, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical	0 800		

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0 800	Continued From page 7 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 December 9, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 8 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 9 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 9, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

(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
01060	Continued From page 10 information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content to the resident, legal representative, and designated representative in the event of an emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Service Plan Agreement dated, September	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36983	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

(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
01060	Continued From page 11 9, 2025, indicated R2 received services including assistance with behavior management, safety checks, housekeeping, laundry, and meals. R2's Nursing/Behavioral Note, dated October 29, 2025, indicated: -on October 28, 2025, "Client was agitated. He turned the water faucets in multiple areas to cause flooding. He also came aggressively into the office, grabbed the office phone and threw it to the ground, breaking the facility phone. Client also verbally abused staff." -"Client continues to have labile mood and aggressive behaviors. Client's legal guardian chose to civilly commit client to the hospital after manager spoke to her about client's increased behavioral symptoms." - "The licensee worked with the Richfield Police and their Behavioral Response team to transfer client to the hospital. Client eloped when the police initially came to the facility on [October 29, 2025]. Client came back to [the licensee] after the police left. [the licensee] called the police and the behavioral response team when client came back to the program. Client was tearful but agreed to a transfer to [the hospital]. R2's Nursing/Behavioral Note, dated November 17, 2025, indicated "Client was admitted into [hospital] because his legal guardian revoked his civil commitment due to client's aggression towards staff and the facility as well as client's lack of medication adherence. Police and paramedics transported client to the hospital. Client was hospitalized from October 29, 2025, to November 17, 2025." R2's record lacked evidence a written notice was provided to the resident, legal representative, and designated representative, that contained:	01060		

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	36983	A. BUILDING: _____ B. WING _____	12/11/2025

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FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

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01060	Continued From page 12 -the reason for the relocation, -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. The record lacked evidence the notification was provided to the Office of Ombudsman for Long-Term Care when the resident had not returned to the facility within four days. On December 9, 2025, at 3:40 p.m., the clinical nurse supervisor (CNS)-B, stated R2 was admitted to the hospital October 29, 2025, through November 17, 2025, related to verbal and physical aggression and escalating behavior. On December 11, 2025, at 4:15 p.m., CNS-B stated nursing was responsible to complete the required documentation for an emergency relocation including a written notice with the required content to the resident, legal representative, and designated representative. CNS-B explained although the licensee was aware of this regulation, it may have been overlooked due to increased chaos. CNS-B explained the licensee did not expect R2 to return to the facility.	01060		

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01060	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided direct supervision of staff performing delegated tasks within 30 calendar days after the date on which the	01440		

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01440	Continued From page 14 individual begins performing the delegated task for one of one employee (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) 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: ULP-C was hired on August 13, 2025, to provide direct care and services to residents of the facility. On December 9, 2025, at 9:00 a.m., ULP-C was observed assisting R1 with medication administration. ULP-C's employee record lacked documentation of direct supervision by a registered nurse within 30 calendar days from the date on which ULP-C first performed the delegated tasks for residents. On December 11, 2025, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated ULP-C's employee record lacked documentation of a 30-day supervision for the delegated task of medication administration. CNS-C stated nursing was responsible for all ULP training and evaluation including direct supervision of staff performing delegated tasks within 30 calendar days by an RN. CNS-B stated this may have overlooked this because the licensee did not assign a specific nurse to the task. CNS-B stated going forward the licensee would assign ULP	01440		

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FIRST MERCY HOMES LLC	7420 17TH AVENUE SOUTH RICHFIELD, MN 55423

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01440	Continued From page 15 training and evaluation to the CNS. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if	01530		

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01530	Continued From page 16 issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date for one of two employees, 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired August 13, 2025, and provided direct care and services for residents of the facility. On December 9, 2025, at 9:00 a.m., ULP-C was observed assisting R1 with medication administration.	01530		

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01530	Continued From page 17 ULP-C's employee record lacked documentation the required 2 hours of initial training on mental illness and de-escalation topics was completed within 120 hours of the start date, effective July 1, 2025. On December 11, 2025, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of the required 2 hours of initial training on mental illness and de-escalation topics within 120 hours of start date for all direct-care staff. CNS-B explained the licensee would ensure all staff completed the required training prior to providing care and services to the residents residing in the facility. The licensee's De-Escalation Policy, undated, indicated all staff must complete required training under 144G, including de-escalation and mental-illness awareness at hire No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 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 ensure safe oxygen	02310		

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02310	Continued From page 18 storage, according to acceptable health care, medical, or nursing standards 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included pulmonary emphysema chronic obstructive pulmonary disease (COPD) and was oxygen dependent. R1's record indicated R1 required supplemental oxygen at 3.5 liters per minute (LPM) via nasal cannula and used a portable oxygen tank when going into the community. On December 9, 2025, at 2:34 p.m., 16 unsecured oxygen cylinders were observed on the floor in a corner of R1's bedroom. In addition, two additional unsecured oxygen cylinders were observed behind a reclining chair and another oxygen cylinder placed sidewards in a handbag also in R1's room. R1 stated the cylinders had never been secured in a rack. The clinical nurse supervisor (CNS)-B, stated they were unaware of the storage requirements for oxygen cylinders. On December 9, 2025, at 3:40 p.m., CNS-B stated all oxygen cylinders should be secured in a rack and in a locked area.	02310		

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02310	Continued From page 19 The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. The licensee's Oxygen Tank and Storage Policy, undated, indicated oxygen tanks must be stored upright in a secure location using approved tank holders, racks, or carts to prevent tipping or falling No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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

FIRST MERCY HOMES LLC
7420 17th Avenue South
Richfield, MN 55423
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36983

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

Inspection Info

Report Number: F1039251227
Inspection Type: Full - Single
Date: 12/9/2025 Time: 11:30
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 4
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: PREVIOUS CFPM IS EXPIRED. COMPLY WITH ABOVE RULE. DETAILS ON CFPM PROGRAM SENT WITH REPORT.
Comply By: 12/9/2025 Originally Issued On: 12/9/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: WET WIPING CLOTH HUNG ON CABINET DRAWER HANDLE. STORE WIPING CLOTHS IN BLEACH/QUAT. SANITIZER SOLUTION OR USE NO WET WIPING CLOTHS. CLOTH DISCARDED.
Comply By: 12/9/2025 Originally Issued On: 12/9/2025

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: DATE MARK MISSING FROM OPEN PACKAGED OF SHREDDED CHEESE. COMPLY WITH ABOVE RULE. GUIDANCE DOCUMENT ON DATE MARKING SENT WITH REPORT.
Comply By: 12/9/2025 Originally Issued On: 12/9/2025

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: COOKED FOODS FROM PREVIOUS DAYS ARE HELD IN COOLERS. FOODS DISCARDED. COMPLY WITH ABOVE RULE. ESTABLISHMENT IS EQUIPPED TO OFFER SAME-DAY SERVICE ONLY.
Comply By: 12/9/2025 Originally Issued On: 12/9/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: *REISSUE FROM PREVIOUS INSPECTION 9/3/24* NO SMALL DIAMETER FOOD PROBE THERMOMETER. COMPLY WITH ABOVE RULE.
Comply By: 12/9/2025 Originally Issued On: 12/9/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: PER STAFF, SOME DISHES ARE WASHED BY HAND WITH SOAP AND WATER ONLY. USE RESIDENTIAL DISHWASHING MACHINE ON SANITIZE CYCLE FOR ALL DISHES. OTHER FOOD CONTACT SURFACES MAY BE CLEANED-IN-PLACE AND SANITIZED WITH A BLEACH OR QUAT. SOLUTION.
Comply By: 12/9/2025 Originally Issued On: 12/9/2025

New Order: 5-200A Plumbing: approved materials/design
5-201.11B *Priority Level: Priority 3 CFP#: 51*
MN Rule 4626.1040B Maintain the plumbing system in good repair.
COMMENT: KITCHEN FAUCET IS LOOSE IN SINK. TIGHTEN FAUCET INTO MOUNTING.
Comply By: 12/16/2025 Originally Issued On: 12/9/2025

Food & Beverage General Comment

BUTTER - COLD HOLD, REFRIGERATOR - 39 DEGREES F
MILK - COLD HOLD, FRONT ROOM/2ND REFRIGERATOR - 41 DEGREES F

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Mary Bruess.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base AND painted walls and ceiling. These kitchen finishes and surfaces show some signs of wear. Establishment should maintain or repair facilities and equipment to be smooth, durable and easily cleanable.

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

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

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 F1039251227 from 12/9/2025

Abdul Qudoos Farah
person-in-charge

Aron Goodner,
Public Health Sanitarian 1

651-201-4910
aron.goodner@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

FIRST MERCY HOMES LLC
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F1039251227
Inspection Type: Full
Date: 12/9/2025
Time: 11:30

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Greater Than 150 Degrees F.
Comment: NSF RESIDENTIAL DISHWASHING MACHINE
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36983016-0	**Date:** December 9, 2025
Facility Name: FIRST MERCY HOMES LLC	
Facility Address: 7420 17TH AVENUE S, RICHFIELD, MN, 55423	

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms 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: Smoke alarms were not interconnected when tested.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) 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: Damaged walls in the kitchen, basement office, living room and resident room #1. Missing door jambs from the rear exit and kitchen door frames.

☒ **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 FSEP, from a third-party consultant, included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Facility had resident procedures in a different policy/plan and will add to the FSEP.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or if the information is located in a separate location and how to access. The plan also fails to instruct staff what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

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

   Comments: Surveyor requested all documentation for staff training on the FSEP from the clinical nurse specialist (CNS)-B and house manager (HM)-C. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. CNS-B/HM-C provided a sheet of paper titled staff training which had dates next to each staff members name. HM-C stated those were start dates; no signatures and no other dates for continuous education was provided.

5. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: Surveyor requested all staff training on the FSEP from the registered nurse (CNS)-B and house manager (HM)-C. CNS-B/HM-C, lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.