Electronically Delivered

June 9, 2025

Licensee
Midwest Homes Inc.
1628 Keller Drive
Burnsville, MN 55306

RE: Project Number(s) SL35647016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 29, 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, 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:

**0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00**
**0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00**

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 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35647 | A. BUILDING: _____ B. WING _____ | 04/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIDWEST HOMES INC | 1628 KELLER DRIVE BURNSVILLE, MN 55306 |

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| 0 000 | Initial Comments<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL35647016-0<br><br>On April 28, 2025, through April 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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;<br>(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<br><br>allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer | 0 480 | | |

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| 0 480 | Continued From page 3<br>to the FBEIR for any compliance dates. | 0 480 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors.<br><br>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 | 0 550 | | |

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| 0 550 | Continued From page 4<br><br>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).<br><br>The findings include:<br><br>On April 28, 2025, at 12:55 p.m., the surveyor observed the facility's postings. These postings did not include the required contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br><br>On April 28, 2025, at 1:00 p.m., licensed assisted living director (LALD)-A stated the posting was previously on the bulletin board with other postings; however, somehow it was removed and she was not aware until now.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to | 0 680 | | |

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| 0 680 | Continued From page 5<br><br>all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements.<br><br>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 the residents).<br><br>The findings include:<br><br>On April 28, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-B provided the surveyor with the licensee's EP plan for review dated as reviewed and updated March 2025. | 0 680 | | |

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| 0 680 | Continued From page 6<br><br>The licensee lacked the following required information according to Emergency Preparedness: Appendix Z:<br>- risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs);<br>- document risk assessment for an all-hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community-based risks (evacuation plans, staffing surges/shortages, back-up plans);<br>- a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response;<br>- policy and procedure based on the EP risk assessment and communication plan;<br>- policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies;<br>- policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal;<br>- policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location;<br>- policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility;<br>- policy and procedure addressing use of | 0 680 | | |

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| 0 680 | Continued From page 7<br><br>volunteers, including the process/role for integration;<br>- policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT;<br>- develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers;<br>- communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives;<br>- conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise.<br><br>Additionally, the EP plan lacked evidence the Missing Resident policy/procedure was reviewed every 90 days, as required.<br><br>On April 29, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A and CNS-B stated since the previous survey, they had put the EP plan together; however, they were not clear on the required content.<br><br>The licensee's Emergency Preparedness Policy-Appendix Z compliance policy dated | 0 680 | | |

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| 0 680 | Continued From page 8<br><br>August 1, 2021, indicated [licensee name] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components:<br><br>1. Risk assessment and planning<br>2. Policies and procedures<br>3. A communication plan<br>4. Staff training and exercises/drills<br><br>[licensee name] utilized a hazard vulnerability analysis tool to measure threats and hazards of concern, probability of events, measurements regarding the context of impact on people, property, and business, preparedness, and mitigation.<br><br>[licensee name] emergency preparedness plan includes policies and procedures designed to align with the LTC requirements in Appendix Z.<br><br>[licensee name] emergency preparedness plan includes a communications plan focusing on staff, entities under arrangement, other LTC providers, volunteers, family members, state and federal contacts, and other sources of assistance. The communications plan is designed to share information and medical documentation regarding residents under our care to maintain continuity of care during an emergency.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 680 | | |

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| 0 730 | Continued From page 9 | 0 730 | | |
| 0 730 SS=F | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received | 0 730 | | |

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| 0 730 | Continued From page 10<br><br>and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure documentation of services provided for one of one resident (R1).<br><br>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).<br><br>The findings include:<br><br>R1 began receiving services from the licensee on June 1, 2020, with diagnoses including schizophrenia.<br><br>R1's Service Plan dated June 1, 2024, included medication administration, meal preparation, cues for oral care, showers/grooming, and behavior management.<br><br>On April 29, 2025, at 8:47 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. | 0 730 | | |

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| 0 730 | Continued From page 11<br><br>R1's Services Charting Sheet dated April 1-29, 2025, included the services of oral hygiene, grooming, meal prep, snacks, behavior support, and sleep/awake tracking.<br><br>R1's Services Charting Sheet lacked documentation of the following services:<br>-Oral hygiene cues/resident completion-missing documentation on April 3, 4, 10, 14, 18, 19, 20, 27, 2025;<br>-grooming cues/resident completion-missing documentation on April 3, 4, 10, 14, 19, 20, 23, 27, 2025;<br>-meal prep-missing documentation on April 19, 2025;<br>-snack-missing documentation on April 19, 26, 2025;<br>Furthermore, on several days throughout the month when (-) was indicated for a task not being completed, there was no indication about "why" the task was not completed.<br><br>The licensee failed to consistently document the services completed.<br><br>On April 29, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated she had recently noted the missing documentation and was following up with the program manager and staff regarding the expectation to complete documentation of services every day. She further stated when (-) was noted as a task was not completed, the staff were to enter an additional comment into the record as to why the task was not completed. CNS-B stated the staff on duty indicated they were not aware they needed to add additional comments.<br><br>The licensee's undated, Resident Record policy | 0 730 | | |

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| 0 730 | Continued From page 12<br><br>indicated the resident record would include documentation that services have been provided as identified in the service plan<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTIONS:<br>Twenty-one (21) days | 0 730 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On April 29, 2025, from approximately 10:20 a.m. to 11:50 a.m., the surveyor toured the facility with the licensed assisted living director (LALD)-A. During the tour, the surveyor observed the | 0 775 | | |

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| 0 775 | Continued From page 13<br>following deficient conditions:<br><br>SMOKING<br><br>A significant number of discarded smoking materials were located on the ground near the front entry around the smoking receptacle and in the vegetation near the front porch. LALD-A instructed residents to clean up the area and discarded cigarette butts were removed during the survey. Facility should be maintained free of discarded smoking materials on the ground and all such materials should be disposed of in approved receptacles.<br><br>EGRESS WINDOW<br><br>The egress window in resident room 1 had a broken crank that was difficult to open. The resident of the room mentioned difficulty opening the window. Egress window assembly should be maintained easily openable and in proper working order.<br>On April 28, 2025, the surveyor explained to LALD-A the requirements for smoking materials and egress windows. LALD-A stated they understood requirements and would make appropriate changes.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days. | 0 775 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes; | 0 780 | | |

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| 0 780 | Continued From page 14<br><br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>Findings include:<br><br>On April 29, 2025, from approximately 10:20 a.m. | 0 780 | | |

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| 0 780 | Continued From page 15<br><br>to 11:50 a.m., the surveyor toured the facility with the licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following deficient conditions:<br><br>The smoke alarms in resident rooms 1, 2, 3, 5 and 6 were not properly interconnected. The surveyor requested for the alarms to be tested, and LALD-A instructed unlicensed personnel (ULP)-E to test the alarms. ULP-E test smoke alarms by actuating alarms in the basement and dining room multiple times. It was observed that the actuation of these alarms did not cause alarms in resident room 1, 2, 3, 5, or 6 to sound. LALD-A stated that smoke alarms had been all properly interconnected when tested a week before the survey. LALD-A tested smoke alarms in resident rooms 1, 2, and 3 and in each case activation of these alarms did not cause any other alarms to sound. Smoke alarms are required to be installed inside and outside in the immediate vicinity of all sleeping rooms. All smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility.<br><br>When tested, the smoke alarm in resident room 2 was not functional and did not sound. LALD-A tested the alarm and was not able to get the alarm to activate. LALD-A acknowledged the alarm was not operational. Smoke alarms must be maintained in proper working order and are required to be functional when tested.<br><br>During the tour LALD-A verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. LALD-A verified they understood the requirement and would establish full interconnection and functionality of smoke alarm in resident room 2. | 0 780 | | |

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| 0 780 | Continued From page 16<br><br>TIME PERIOD FOR CORRECTION: Two (2) days. | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On April 29, 2025, from approximately 10:20 a.m. to 11:50 a.m., the surveyor toured the facility with | 0 800 | | |

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| 0 800 | Continued From page 17<br><br>the licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following deficient conditions:<br><br>There were burn marks on the carpet in resident room 2. Flooring should be maintained in good condition and although the source of the burn marks was no evident, any burns may pose risk of fire hazard. LALD-A indicated that the burn marks were old and no current source of making the marks was present.<br><br>Half of a step was missing on the stairs to rear patio where a board had broken, leaving screws exposed and steps unsafe and a tripping or falling hazard.<br><br>The railing along the rear steps to the back patio was loose and wiggle when gripped and should be securely attached to the patio assembly.<br><br>The caulking along the top of the bathroom shower in the basement was discolored and worn, potentially water damaged and sullied. Shower should be maintained in good condition free of discoloring.<br><br>There was a hole in the wall in resident room 6. Holes should be repaired, and walls maintained in proper condition.<br><br>There was a hole in the wall of the garage. Holes should be repaired, and walls maintained in proper condition.<br><br>An outlet in the garage had a damaged outlet cover, which should be repaired or replaced to fully cover electrical wiring and components.<br><br>A sconce in the basement near resident room 4 | 0 800 | | |

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| 0 800 | Continued From page 18<br>was missing a light bulb and had the fixture exposed.<br><br>Window screens were damaged in resident room 1 and resident room 2.<br><br>Resident room 2 was missing light bulbs and a globe around a lamp, exposing the electrical fixture.<br><br>Resident room 4 had a handle grip near the egress window which had loose screws that had entirely pulled away from the wall on the top and was hanging loose.<br><br>One of the doors to the mechanical/storage room in the basement was unopenable by staff during inspection and was stuck closed. The room was accessible by a side door, but all doors should be easily openable.<br><br>There were several holes in the front porch pillars. LALD-A stated that these were caused by woodpeckers, but other animals could gain access to the holes.<br><br>During the facility tour interview on April 29, 2025, LALD-A verified the above listed physical environment observation while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The | 0 810 | | |

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| 0 810 | Continued From page 19<br><br>plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and documentation. This had the potential to directly affect all residents, staff, and visitors. | 0 810 | | |

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| 0 810 | Continued From page 20<br><br>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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On April 29, 2025, at approximately 11:30 a.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training.<br><br>The licensee FSEP failed to include the following:<br><br>The FSEP did not include fire procedures for employees. Information was available online with procedures for another facility, but nothing was developed or readily available in the FSEP. LALD-A stated that plans would be developed and included in the FSEP.<br><br>The FSEP should include employee actions to be taken in event of fire or similar emergency.<br><br>The FSEP did not include fire procedures for residents. The FSEP should include plans for residents to follow during evacuation.<br><br>The FSEP did not include any documentation of trainings provided to residents on evacuation. Trainings should be made available to residents at least once a year.<br><br>The FSEP did not include any documentation of trainings provided to staff on the FSEP. Staff | 0 810 | | |

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| 0 810 | Continued From page 21<br><br>should receive training on the FSEP upon hire and at least twice a year thereafter and such training should be documented.<br><br>The FSEP did not include any documentation on trainings provided to residents on fire or evacuation procedures. Residents should be offered training on proper actions to take in event of fire or evacuation at least once per year.<br><br>The FSEP did not include evacuation maps that did not include location and room numbers for resident rooms and provided maps posted around the facility were inaccurate and mislabeled bedroom numbers and indicated that a storage room was a bedroom. Room locations should be accurately identified and numbered and provided in the FSEP. LALD-A stated that maps were outdated and would be updated.<br><br>Records of facility drills indicated that evacuation drills had been conducted on 1/10/25, 11/8/24, 10/24/24, 7/28/24, 4/25/24 and 1/8/24. The overnight shift was also only involved in the drill on 10/24/24 in the past year. Evacuation drills conducted were insufficient. Evacuation drills are required for employees twice per year per shift and at least once every other month.<br><br>During the record review and interview on April 29, 2025, LALD-A verified the above listed documents were absent from the FSEP. LALD-A stated that they understood requirements and would supplement the existing FSEP with missing information and documents.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |

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| 01290 | Continued From page 22 | 01290 | | |
| 01290 SS=F | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of eight employees (unlicensed personnel (ULP)-D) was affiliated with the assisted living license as required.<br><br>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).<br><br>The findings include: | 01290 | | |

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| 01290 | Continued From page 23<br><br>ULP-D<br>ULP-D was hired on November 14, 2024, to provide direct care services to the licensee's residents.<br><br>On April 28, 2025, at 3:15 p.m., the licensee provided the surveyor their NETStudy Roster printed that day. The NETStudy roster indicated ULP-D had a cleared background study for a separate location (the licensee's other assisted living facility) under health facility identification (HFID) 35007. ULP-D's record lacked evidence the licensee affiliated a background study under this license (HFID 35647).<br><br>On April 29, 2025, at 8:30 a.m., licensed assisted living director (LALD)-A stated ULP-D worked overnight shift and provided direct care services. LALD-A stated when new ULPs were hired, LALD-A or the program manager ensured each new hire was affiliated with both facilities the LALD managed. She stated this must have been missed.<br><br>The licensee's Background Study policy dated August 1, 2021, indicated [licensee name] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [licensee name]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [licensee name] will not employ individuals whose results of the background study indicate disqualification for the position.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) | 01290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35647 | A. BUILDING: _____ B. WING _____ | 04/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIDWEST HOMES INC | 1628 KELLER DRIVE BURNSVILLE, MN 55306 |

| (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 |
|---|---|---|---|---|
| 01290 | Continued From page 24<br>days | 01290 | | |
| 01500 SS=D | 144G.63 Subd. 5 Required annual training<br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35647 | A. BUILDING: _____ B. WING _____ | 04/29/2025 |

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|---|---|
| MIDWEST HOMES INC | 1628 KELLER DRIVE BURNSVILLE, MN 55306 |

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|---|---|---|---|---|
| 01500 | Continued From page 25<br><br>annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (program manager (PM)-C).<br><br>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).<br><br>The findings include: | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35647 | A. BUILDING: _____ B. WING _____ | 04/29/2025 |

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|---|---|
| MIDWEST HOMES INC | 1628 KELLER DRIVE BURNSVILLE, MN 55306 |

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|---|---|---|---|---|
| 01500 | Continued From page 26<br><br>PM-C began providing direct care services on May 8, 2023, under the licensee's assisted living license.<br><br>PM-C's employee record included Educare (the licensee's online training resource) training transcripts; however, the training transcripts lacked evidence the employee had successfully completed annual training to include the following required training topics:<br>-reporting maltreatment of vulnerable adults or minors (last completed May 8, 2023);<br>-infection control techniques (last completed June 27, 2023);<br>-a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures (last completed May 31, 2023; and<br>-principles of person-centered planning/service delivery (last completed May 31, 2023)<br><br>Additionally, PM-C's training document did not reflect the required eight hours of annual training.<br><br>On April 29, 2025, at 2:40 p.m., licensed assisted living director (LALD)-A stated she assigned all staff training and needed to refer to her check off list more closely when assigning trainings for the staff.<br><br>The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated:<br>All staff that perform direct care services at [licensee name] will complete at least eight (8) hours of annual training for each 12 months of employment.<br>The following training elements MUST be included every 12 months to all staff who performs direct care services: | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35647 | A. BUILDING: _____ B. WING _____ | 04/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIDWEST HOMES INC | 1628 KELLER DRIVE BURNSVILLE, MN 55306 |

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|---|---|---|---|---|
| 01500 | Continued From page 27<br>1. Training on reporting of maltreatment of vulnerable adults under section 626.557<br>2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights<br>3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases<br>4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders<br>5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures<br>6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01500 | | |

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

Midwest Homes Inc
1628 Keller Drive
Burnsville, MN 55306
Dakota County
Parcel:

Phone:

## License Info

License: HFID 35647

Risk:
License:
Expires on:
CFPM: BOAKAI A KIANDOLI
CFPM #: 123135; Exp: 05/03/2027

## Inspection Info

Report Number: F1018251003
Inspection Type: Full - Single
Date: 4/28/2025 Time: 3:28:32 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

**! New Order: 3-300B Protection from Contamination: cross-contamination, eggs**

3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

*MN Rule 4626.0235A(1)* Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: RAW SHELL EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE COOLER. COMPLY WITH RULE.

*Comply By: 4/28/2025 Originally Issued On: 4/28/2025*

# Food & Beverage General Comment

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.
ESTABLISHMENT IS DOING ALL SAME DAY SERVICE OF FOODS.
FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN FAIR CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.
KITCHEN HAS A TWO BASIN SINK AND ONE SINK SPECIFICALLY FOR HAND WASHING.
DISHWASHER HAS SANITIZE FUNCTION AVAILABLE. TEST STRIP INDICATED APPROPRIATE TEMPERATURE WAS ACHIEVED DURING CYCLE.
ESTABLISHMENT HAS A NEEDLE POINT THERMOMETER FOR CHECKING FOOD TEMPERATURES.
DISCUSSED PEST CONTROL AND ILLNESS REPORTING.
VIEWED EMPLOYEE ILLNESS LOG.

**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 F1018251003 from 4/28/2025**

Establishment Representative

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777

rebecca.prestwood@state.mn.us

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

# Temperature Observations/Recordings



## Establishment Info

Midwest Homes Inc
Burnsville
County/Group: Dakota County

## Inspection Info

Report Number: F1018251003
Inspection Type: Full
Date: 4/28/2025
Time: 3:28:32 PM

**Food Temperature: Product/Item/Unit:** CHEESE**; Temperature Process:** Cold-Holding
**Location:** Reach-in Cooler at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** BUTTER**; Temperature Process:** Cold-Holding
**Location:** Reach-in Cooler at 40 Degrees F.
Comment:
*Violation Issued?: No*

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

# Sanitizer Observations/Recordings



## Establishment Info

Midwest Homes Inc
Burnsville
County/Group: Dakota County

## Inspection Info

Report Number: F1018251003
Inspection Type: Full
Date: 4/28/2025
Time: 3:28:32 PM

**Sanitizing Equipment:** **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
**Location:** **Equal To** 160 Degrees F.
Comment:
*Violation Issued?: No*