Electronically Delivered

May 20, 2026

Licensee
Elite Nursing Services Inc.
3100 Thurber Road
Brooklyn Center, MN 55430

RE: Project Number(s) SL36036016

Dear Licensee:

On April 8, 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 August 7, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 7, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 7, 2025, found not corrected at the time of the April 8, 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) - $1,000.00

The details of the violations noted at the time of this follow-up survey completed on April 8, 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 Tim Hanna at 507-208-8982.

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,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 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
	36036	A. BUILDING: _____ B. WING _____	R 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36036016-3 On April 8, 2026, the Minnesota Department of Health conducted a deck follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on August 8, 2025. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required	{0 110}		

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 110}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	{0 470}		

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{0 470}	Continued From page 2 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 470}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 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	{0 480}		

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{0 480}	Continued From page 3 manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and 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: Not reviewed during this survey.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must	{0 485}		

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{0 485}	Continued From page 4 be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 485}		
{0 650} SS=F	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	{0 650}		

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{0 650}	Continued From page 5 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: Not reviewed during this survey.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	{0 680}		

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{0 680}	Continued From page 6 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;	{0 730}		

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{0 730}	Continued From page 7 (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; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (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; (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; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 730}		

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{0 780} SS=I	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 and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. The deficient condition has the ability to affect all staff and residents.	{0 780}		

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{0 780}	Continued From page 9 This practice resulted in a level three violation (a violation that harmed a client's/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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 clients/residents). The findings include: On facility tour with administrator (A)-C on April 8, 2026, between 9:00 a.m. and 9:30 a.m. the following deficient condition was observed: SMOKE ALARMS: The A-C checked the interconnection of the smoke alarms and the other smoke alarms in the facility did not operate when tested. The A-C stated they were working on installing hardwired smoke alarms that will all be interconnected. All smoke alarms in the facility shall be interconnected. The deficient condition was visually verified by the A-C accompanying on the tour.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	{0 810}		

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{0 810}	Continued From page 10 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 810}		
{01530} SS=F	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	{01530}		

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{01530}	Continued From page 11 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 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: Not reviewed during this survey.	{01530}		

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{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01650}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	{01910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36036	A. BUILDING: _____ B. WING _____	R 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

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{01910}	Continued From page 13 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01910}		

Electronically Delivered

February 6, 2026

Licensee
Elite Nursing Services Inc
3100 Thurber Road
Brooklyn Center, MN 55430

RE: Project Number(s) SL36036016

Dear Licensee:

On January 21, 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 August 7, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 7, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 7, 2025, found not corrected at the time of the January 21, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $3,000.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $1,000.00

The details of the violations noted at the time of this follow-up survey completed on January 21, 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 $4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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 Tim Hanna at 507-208-8982.

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,

Tim Hanna, Supervisor
State Evaluation Team
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36036	A. BUILDING: _____ B. WING _____	R 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

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{0 000}	Initial Comments	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required	{0 110}		

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 110}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	{0 470}		

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{0 470}	Continued From page 2 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 470}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 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	{0 480}		

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{0 480}	Continued From page 3 manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and 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: Not reviewed during this survey.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must	{0 485}		

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{0 485}	Continued From page 4 be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 485}		
{0 650} SS=F	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	{0 650}		

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{0 650}	Continued From page 5 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: Not reviewed during this survey.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	{0 680}		

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{0 680}	Continued From page 6 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;	{0 730}		

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{0 730}	Continued From page 7 (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; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (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; (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; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 730}		

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{0 775} SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code. The deficient condition has the ability to affect all staff and residents. This practice resulted in a level four violation (a violation harmed a client's/resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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 clients/residents). The findings include: On facility tour with administrator (A)-C on January 20, 2026, between 9:30 a.m. and 10:00 a.m. the following deficient condition was observed: Compliant emergency escape rescue openings were not provided in resident rooms. Upper-level resident room 1 and 3 emergency escape and rescue clear window opening measurements are 18" wide x 37" high. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum clear opening dimension of 20 inches in height and a minimum clear opening dimension of 20 inches in	{0 775}		

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{0 775}	Continued From page 9 width with at least one compliant emergency escape and rescue opening required within each resident sleeping room. Measurements were taken by the surveyor with A-C present and observing. The A-C stated a permit had been applied for to replace the windows. These deficient conditions were visually verified by A-C accompanying on the tour. The surveyor explained that an immediate correction order will be issued for the above findings. The deficient condition was visually verified by A-C accompanying on the tour.	{0 775}		
{0 780} SS=I	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	{0 780}		

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{0 780}	Continued From page 10 (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 and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. The deficient condition has the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a client's/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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 clients/residents). The findings include: On facility tour with administrator (A)-C on January 20, 2026, between 9:30 a.m. and 10:00 a.m. the following deficient condition was observed: SMOKE ALARMS: The A-C checked the interconnection of the smoke alarms and the other smoke alarms in the facility did not operate when tested.	{0 780}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

(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
{0 780}	Continued From page 11 All smoke alarms in the facility shall be interconnected. The deficient condition was visually verified by the A-C accompanying on the tour.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not	{0 810}		

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{0 810}	Continued From page 12 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 810}		
{01530} SS=F	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	{01530}		

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{01530}	Continued From page 13 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: Not reviewed during this survey.	{01530}		
{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	{01650}		

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{01650}	Continued From page 14 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01650}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	{01910}		

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{01910}	Continued From page 15 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01910}		

Electronically Delivered

December 2, 2025

Licensee
Elite Nursing Services Inc
3100 Thurber Road
Brooklyn Center, MN 55430

RE: Project Number(s) SL36036016

Dear Licensee:

On October 29, 2025, 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 August 7, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 7, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 7, 2025, found not corrected at the time of the October 29, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $3,000.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $1,000.00

The details of the violations noted at the time of this follow-up survey completed on October 29, 2025 (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 $4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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 Jess Schoenecker at 651-201-3789.

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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	36036	A. BUILDING: _____ B. WING _____	R 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36036016-1 On October 28, 2025, to October 29, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 8, 2025. At the time of the survey, there were two residents; two receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required	{0 110}		

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 28, 2025, at 8:25 a.m., the BELTSS website indicated the health facility identification number (HFID) 36036 had LALD-G listed as the residency permit director, but this had ended on October 15, 2024. The website did not list another LALD as the Director of Record for the licensee's HFID. On October 28, 2025, at 10:35 a.m., in an email	{0 110}		

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{0 110}	Continued From page 2 from the licensee, the licensee confirmed licensed assisted living director (LALD)-F was the current LALD for the facility. The licensee's undated Survey Correction Orders indicated under tag 0110, the plan of correction as followed but did not address the LALD being listed as the Director of Records for HFID 36036 through BELTSS: - the facility has designated a qualified individual who holds a current Assisted Living Director license to oversee operations and ensure regulatory compliance; - the Director 's license has been verified and documented in the personnel file; and - the Assisted Living Director has assumed responsibility for day-to-day operations effective immediately. On October 28, 2025, at 1:54 p.m., LALD-F stated they had notified BELTSS to be added to HFID 36036 as the Director of Records back in August. LALD-F stated they did not know how long it takes BELTSS but every time they looked on the website, it indicated the application was still there. On October 29, 2025, at 11:12 a.m., LALD-F indicated they had applied to BELTSS for licensee; and had left messages with BELTSS to check on the progress of the application. LALD-F stated they would provide an update as soon as they were able to speak with someone from BELTSS. The licensee's undated Assisted Living Director policy indicated the licensee expected the LALD to comply with all requirements set forth by BELTSS.	{0 110}		

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{0 110}	Continued From page 3 This citation had correction date period of two days to be completed from September 23, 2025, to September 25, 2025. No further information was provided.	{0 110}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	{0 470}		

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{0 470}	Continued From page 4 This MN Requirement is not met as evidenced by:	{0 470}	Not reviewed during the survey	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 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	{0 480}		

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{0 480}	Continued From page 5 install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and 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 the survey	
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of	{0 485}		

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{0 485}	Continued From page 6 similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during the survey	
{0 650} SS=F	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.	{0 650}		

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{0 650}	Continued From page 7 This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during the survey	
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during the survey	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	{0 680}		

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	36036	A. BUILDING: _____ B. WING _____	R 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

(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
{0 680}	Continued From page 8 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during the survey	
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	{0 730}		

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{0 730}	Continued From page 9 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (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; (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; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}	Not reviewed during the survey	

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{0 775}	Continued From page 10	{0 775}		
{0 775} SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code. The deficient condition has the ability to affect all staff and residents. This practice resulted in a level four violation (a violation harmed a client's/resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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 clients/residents). The findings include: On a facility tour on October 28, 2025, between 12:30 p.m. and 1:30 p.m. with agent (A)-C the surveyor observed that compliant emergency escape rescue openings were not provided in resident rooms. Upper-level resident room 3 emergency escape and rescue clear window opening measurements are 18" wide x 37" high. I did get into resident room 1 and the measurements are 18" wide x 37" high. Existing emergency escape and rescue openings are required to meet a minimum clear	{0 775}		

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{0 775}	Continued From page 11 opening area of 648 square inches and have a minimum clear opening dimension of 20 inches in height and a minimum clear opening dimension of 20 inches in width with at least one compliant emergency escape and rescue opening required within each resident sleeping room. Measure-ments were taken by the surveyor with A-C present and observing. These deficient conditions were visually verified by A-C accompanying on the tour. The surveyor explained that an immediate correction order will be issued for the above findings. SMOKE ALARMS: The surveyor observed that there was not a smoke alarm present inside resident room 1. Provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms, 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. OXYGEN STORAGE: The surveyor observed cylinders of oxygen in the garage that were not stored securely and leaning over and laying on the ground. All oxygen cylinders shall be stored securely. The deficient conditions were visually verified by A-C accompanying on the tour.	{0 775}		

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{0 780}	Continued From page 12	{0 780}		
{0 780} SS=I	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 and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. The deficient condition has the ability	{0 780}		

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{0 780}	Continued From page 13 to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a client's/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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 clients/residents). The findings include: On facility tour with administrator (A)-C on October 28, 2025, between 12:30 p.m. and 1:30 p.m. the following deficient condition was observed: SMOKE ALARMS: The A-C checked the interconnection of the smoke alarms and the other smoke alarms in the facility did not operate when tested. All smoke alarms in the facility shall be interconnected. The deficient condition was visually verified by the A-C accompanying on the tour.	{0 780}		
{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	{0 810}		

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{0 810}	Continued From page 14 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{01530} SS=F	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:	{01530}		

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{01530}	Continued From page 15 (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 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;	{01530}		

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{01530}	Continued From page 16 This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during the survey	
{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}	Not reviewed during the survey	

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{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during the survey	

AMENDED

Electronically Delivered

November 13, 2025

Licensee
Elite Nursing Services Inc
3100 Thurber Road
Brooklyn Center, MN 55430

RE: Project Number(s) SL36036016

Dear Licensee:

Please note: This letter amends the previous notice dated September 23, 2025. Specifically, the scope and level of tag identification 0810 was lowered, the fine for tag 0810 rescinded and the total amount of fines assessed pursuant to this survey has been corrected. You have the right to request a reconsideration within the statutory timeline for the corrected 0810 tag. The reconsideration deadline for the remaining penalty tags has expired. No other changes were made.

The Minnesota Department of Health (MDH) completed a survey on August 7, 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.

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 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - $1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $3,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. 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,

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

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL36036016-0 On August 4, 2025, through August 7, 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 two residents receiving services under the Assisted Living Facility license. An immediate correction order was identified on August 5, 2025, issued for SL36036016-0, tag identification 0775. An immediate correction order was identified on August 6, 2025, issued for SL36036016-0, tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk related to tag identification 1290. Noncompliance	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.	

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ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

(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	Continued From page 1 remained and the scope and level remain unchanged. An immediate correction order was identified on August 6, 2025, issued for SL36036016-0, tag identification 0495. During the course of the survey, the licensee failed to take action to mitigate the imminent risk related to tag identification 0495. The correction order for tag identification numbers 0495 and 1290 contain updated language in the scope and severity level statement at the beginning of the orders, reflecting changes that went into effect July 1, 2025. On November 12, 2025, the scope and level of tag identification 0810 was changed from a level three widespread to a level two widespread. The amended results were sent to the licensee.	0 000		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of	0 110		

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0 110	Continued From page 2 Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 4, 2025, at 7:57 a.m., the BELTSS website indicated the health facility identification number (HFID) 36036 had LALD-G listed as the residency permit director, but this had ended on October 15, 2024. The website did not list another LALD as the director of record for the licensee's HFID. On August 4, 2025, at 10:19 a.m., unlicensed personnel (ULP)-A stated LALD-G still worked for the licensee but stated they had not been to the facility for a while. The surveyor asked ULP-A for an approximate date for the last time they saw LALD-G. ULP-A had a long pause before stating it was the previous week and stated LALD-G would come and go to the facility. On August 4, 2025, at 10:21 a.m., agent (A)-C stated the licensee recently hired LALD-F as the licensee's LALD. On August 4, 2025, at 10:44 a.m., A-C confirmed LALD-G had no longer worked for the licensee.	0 110		

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0 110	Continued From page 3 LALD-F was hired by the licensee on July 21, 2025, as the LALD. On August 4, 2025, at 1:01 p.m., the BELTSS website indicated LALD-F was issued a license on June 25, 2021, with an expiration date of October 31, 2025. The BELTSS website did not indicate LALD-F was the director of record for the licensee's HFID 36036. On August 7, 2025, at 11:43 a.m., LALD-F stated they were in the active process of adding them as director of record for the licensee at the time of the surveyor interview. LALD-F stated they were not aware they needed to add themselves as the director of record upon hire and stated they were within a window to also renew their LALD license through BELTSS. The licensee's undated Assisted Living Director policy indicated the licensee expected the LALD to comply with all requirements set forth by BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable	0 470		

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0 470	Continued From page 4 unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the staffing plan was developed and reviewed by the clinical nurse supervisor (CNS) as required per Minnesota Administrative Rules 4659.0180. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 470		

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0 470	Continued From page 5 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee did not have a written staffing plan with all the required content developed by a CNS. On August 4, 2025, at 11:35 a.m., CNS-D stated they did not think they had developed a staffing plan recently and had asked the surveyor if they needed to create a staffing plan. Agent (A)-C stated they agreed with CNS-D and stated the staffing plan was something they had not done. On August 6, 2025, at 3:29 p.m., A-C and CNS-D confirmed the licensee did not have a staffing plan written. CNS-D stated they were not aware of the need but would create a staffing plan with all the required content. The licensee's undated Staffing & Scheduling policy indicated the CNS would develop and implement a written staffing plan. The policy referenced Minnesota Administrative Rule 4659.0180, subpart 3 and subpart 4. The policy did not indicate the staffing plan needed to include an evaluation to be conducted at least twice a year. Minnesota Administrative Rule 4659.0180, subpart 3, dated August 11, 2021, indicated a clinical nurse supervisor must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week.	0 470		

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0 470	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 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	0 480		

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0 480	Continued From page 7 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 480		

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0 480	Continued From page 8 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 4, 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 to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer to provide or make available at least three nutritious meals daily	0 485		

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0 485	Continued From page 9 according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines; failed to ensure a menu was prepared a week in advance and provided to the residents; and failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living monthly base fee for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: MEAL AND MENU AVAILABILITY The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated January 7, 2025, indicated the licensee would have available three meals plus snacks as required. On August 4, 2025, at 12:02 a.m., agent (A)-C stated the licensee currently did not provide a menu to residents. A-C stated the licensee's current residents were to provide their own raw food per their choice. A-C stated the licensee currently only provided their residents with meal preparation based on the request from the resident. A-C sated if the resident did not provide the raw food to prepare for them, then the license would use the money paid for the service of meal preparation to pay for their raw food for the next meal.	0 485		

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0 485	Continued From page 10 On August 4, 2025, at 2:07 p.m., resident (R3) stated they were told by their CADI worker it was R3's responsibility to buy their own raw food. R3 stated they have always had their meals provided at other assisted living facilities but did not know why it was different at the current facility. R3 stated not having meals provided affected their mental health as they had never had to deal with purchasing their own food. R3 stated the facility had provided meals everyday but had worried the facility could stop at any time. CONTRACTS R2 R2 was admitted to the licensee on May 19, 2021. R2's Resident Contract for Assisted Living dated February 1, 2024, indicated all services listed on Attachment A were included in the monthly base fee. Attachment A included at least three meals daily with snacks available seven days per week. R3 R3 was admitted to the licensee on February 16, 2025. R3's Resident Contract for Assisted Living dated February 16, 2025, indicated all services listed on Attachment A were included in the monthly base fee. Attachment A included at least three meals daily with snacks available seven days per week. The licensee's undated Assisted Living Contracts policy indicated the minimum requirements for assisted living require three meals and snacks must be made available, and the facility could not	0 485		

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0 485	Continued From page 11 require a resident to include and pay for meals in their contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff and residents had access to a registered nurse (RN) on-call 24-hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee began providing assisted living services on August 1, 2021. At the time of the survey, the licensee had two residents, R2 and R3. Both residents received	0 495	The licensee failed to submit a plan of correction; the scope and severity remain at level 3, widespread.	

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0 495	Continued From page 12 assisted living services. R2's service plan dated April 8, 2025, indicated R2 received services including daily assistance with medication administration. On August 5, 2025, at 8:44 a.m., the surveyor observed ULP-B preparing to assist R2 with medication administration. ULP-B proceeded to attempt to assist R2, who refused the medication. Clinical nurse supervisor (CNS)-D was hired by the licensee on July 9, 2025, to perform all nursing tasks. On August 4, 2025, at 10:21 a.m., agent (A)-C stated CNS-D worked for the licensee part time and was the only nurse at the facility. A-C stated CNS-D also worked for a home care agency and had a job at a hospital. On August 4, 2025, at 10:29 a.m., during the entrance conference, CNS-D stated they worked 32 hours per week at a hospital in the trauma neuro-intensive care unit (ICU). On August 5, 2025, at 8:50 a.m., unlicensed personnel (ULP)-B stated when the nurse was working at their other job, it would take 10 or 15 minutes for the nurse to call back but once in a while the ULP did not get a response for the entire day, and in that situation, they would call A-C and A-C (who was not a RN) would help them. On August 6, 2025, at 2:12 p.m., CNS-D stated they worked at the hospital in the ICU for critically ill patients. CNS-D stated they provided medication administration, worked with	0 495		

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0 495	Continued From page 13 respiratory therapists, and managed patients' ventilators. CNS-D stated they were the charge nurse on the unit, but some shifts they would provide the direct cares and work one on one with the patient, if needed. CNS-D stated they could not recall a time when staff had tried to reach them, and they were not able to get back to the staff. The licensee's Availability of an RN Staff policy dated January 2024, indicated the RN must be readily available either in person, by telephone, or by other means to the staff at all times when the staff provided services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 650 SS=F	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	0 650		

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0 650	Continued From page 14 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-A, ULP-B, clinical nurse supervisor (CNS)-D). 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: ULP-A ULP-A was hired by the licensee on June 11, 2024. ULP-A's employee record lacked evidence of completed annual performance review for 2025. ULP-B ULP-B was hired by the licensee on November 10, 2021.	0 650		

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0 650	Continued From page 15 ULP-B's employee record lacked evidence of completed annual performance review for 2023 and 2022. CNS-D CNS-D was hired by the licensee on July 9, 2024. CNS-D's employee record lacked evidence of completed annual performance review for 2025. On August 5, 2025, at 10:25 a.m., agent (A)-C stated the performance reviews should be done annually. A-C stated they were not sure if ULP-B's performance review for 2025 were completed yet. On August 6, 2025, at 1:46 p.m., A-C stated licensee ULP-A's annual performance review was due; however, it had not been completed yet. In addition, CNS-D's review had not been completed because they did not have anyone to complete nurse reviews. The licensee's undated Personnel Records policy indicated the personnel record for an employee shall include an annual performance evaluation that identified areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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	36036	A. BUILDING: _____ B. WING _____	08/07/2025

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0 660	Continued From page 16 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment and baseline TB Health screening for one of two employees (unlicensed personnel (ULP)-A). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 17 The findings include: FACILITY TB RISK ASSESSMENT The licensee's Facility TB Risk Assessment dated June 2021, was completed on January 23, 2024. The assessment identified the national rate was 2.2 percent and the Minnesota rate was 2.1 percent for 2020. The assessment form and data used to complete the incidence of TB was not current information at the time the assessment was completed. Also, the assessment was blank under the following areas of the assessment: TB screening of health care personnel; TB screening of patients; infection control plan; TB training plan; and quality improvement. On August 4, 2025, at 11:47 a.m., clinical nurse supervisor (CNS)-D stated they were not very familiar with the Facility Tuberculosis (TB) Risk Assessment. Agent (A)-C stated the Facility TB Risk Assessment had been completed a little over a year ago prior to CNS-D's employment with the licensee. ULP-A ULP-A was hired June 11, 2024, and provided direct cares and services for residents of the facility. ULP-A's employee file included a negative TB QuantiFERON Gold Plus (blood test) dated April 10, 2024; however, lacked a baseline TB history and symptom screen. On August 6, 2025, at 1:46 p.m., agent (A)-C stated ULP-A's employee file lacked TB baseline screening upon hire. A-C further stated the registered nurse (RN) was responsible to ensure TB screening and testing was completed at time	0 660		

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0 660	Continued From page 18 of hire. Moreover, A-C stated he would complete employee file reviews and considered the missing documentation an oversite on his part. The licensee's undated Tuberculosis Screening policy indicated each employee or volunteer having direct contact with residents would have documentation of baseline health symptom screening prior to providing care to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680		

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0 680	Continued From page 19 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP updated January 2024, lacked evidence of the following required content: - maintain and annual EP updates; - EP program patient population; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - development of communication plan; - primary/alternate means for communication; - methods for sharing information;	0 680		

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0 680	Continued From page 20 - sharing information on occupancy/needs; and - LTC (long term care) family notifications. On August 6, 2025, at 8:58 a.m., during a review of the facility's EPP with agent (A)-C, A-C stated they were not aware the licensee needed to review the missing resident plan quarterly. The licensee's EPP did not have their delegations of authority updated as the licensee's EPP had previous employees who were no longer employed by the licensee. A-C confirmed the licensee did not have any policies and procedures for at minimum food, water, and pharmaceutical supplies; alternate sources of energy; sewage/waste disposal; sheltering; tracking of staff and residents during an emergency; sheltering, medical documents; use of volunteers; and the role of facility under a waiver declared by the secretary; and methods for sharing information. A-C confirmed the licensee did not have any arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents. The licensee's communication plan was not completed and had blank areas within the communication plan. On August 6, 2025, at 10:26 a.m., A-C confirmed the EPP was missing required content and would work on the missing content for the facility's EPP. The licensee's undated Emergency Management policy indicated the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. The policy did not reference the facility's requirement to also comply	0 680		

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0 680	Continued From page 21 with CMS (Centers for Medicare and Medicaid Services) Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (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; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (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;	0 730		

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0 730	Continued From page 22 (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; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident's record included a discharge summary for one of one discharged 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on February 1, 2024, and	0 730		

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0 730	Continued From page 23 discharged on June 30, 2024. R1's record lacked a discharge summary. On August 5, 2025, at 10:43 a.m., agent (A)-C stated R1 had left the facility to live with family without any notification to the licensee. A-C stated R1's case manager had attempted to get R1 to return to the facility over a period of a few months after they left but R1 had continued to refuse to return as they wanted to live with family. On August 6, 2025, at 2:45 p.m., agent (A)-C stated R1's medical record lacked a discharge summary and documentation of medication disposal. A-C further stated the registered nurse (RN) responsible for the completion of the documentation was no longer employed with the licensee. The licensee's undated Resident Records policy indicated the contents of a resident record would include a discharge summary. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775		

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0 775	Continued From page 24 failed to keep the facility in compliance with Minnesota State Fire Code. The deficient condition has the ability to affect all staff and residents. This practice resulted in a level four violation (a violation harmed a client's/resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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 clients/residents). The findings include: On a facility tour on August 5, 2025, between 9:00 a.m. and 11:30 a.m. with agent (A)-C the surveyor observed that compliant emergency escape rescue openings were not provided in resident rooms. Upper-level resident room 3 emergency escape and rescue clear window opening measurements are 18" wide x 37" high. Based on an exterior observation, the window in resident room 1 appeared to be same size as the window in resident room 3, but exact measurements could not be verified due to the surveyor not being given access to the room during the survey by the provider. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum clear opening dimension of 20 inches in height and a minimum clear opening dimension of 20 inches in width with at least one compliant emergency escape and rescue opening required within each resident sleeping	0 775		

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0 775	Continued From page 25 room. Measurements were taken by the surveyor with A-C present and observing. These deficient conditions were visually verified by A-C accompanying on the tour. The surveyor explained that an immediate correction order will be issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. Additionally on facility tour on August 5, 2025, between 9:00 a.m. and 12:30 p.m. with agent (A)-C the surveyor observed the following conditions: EXTENSION CORD: The surveyor observed that a electrical extension cord was being used in the kitchen and was permanently affixed to structure. Electrical extension cords shall not be used for permanent use and be affixed to the structure. SMOKE ALARMS: The surveyor observed that there was not a smoke alarm present inside resident room 2, 3 and 4. Provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms, 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.	0 775		

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0 775	Continued From page 26 OXYGEN STORAGE: The surveyor observed cylinders of oxygen in the garage that were not stored securely and leaning over and laying on the ground. All oxygen cylinders shall be stored securely. The deficient conditions were visually verified by A-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=I	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	0 780		

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0 780	Continued From page 27 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. The deficient condition has the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a client's/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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 clients/residents). The findings include: On facility tour with administrator (A)-C on August 5, 2025, between 9:00 a.m. and 12:30 p.m. the following deficient condition was observed: SMOKE ALARMS: The A-C checked the interconnection of the smoke alarms and the other smoke alarms in the facility did not operate when tested. All smoke alarms in the facility shall be interconnected.	0 780		

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0 780	Continued From page 28 The deficient condition was visually verified by the A-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 29 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 document required fire safety evacuation training for employees and residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on August 5, 2025, at approximately 12:00 p.m. with the administrator (A)-C on the fire safety and evacuation plan training records for the employees and the residents. TRAINING: The A-C confirmed that they had not documented training on the fire safety and evacuation plan for the employees or residents. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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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
0 810	Continued From page 30 (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (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. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to obtain a cleared Department of Human Services (DHS) background study prior to staff providing services for one of seven employees (unlicensed personnel (ULP)-B). Further the licensee failed to obtain a DHS background study affiliated with the licensee's health facility identification (HFID) for one of seven employees (agent (A)-C). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36036	A. BUILDING: _____ B. WING _____	08/07/2025

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01290	Continued From page 31 cause more than minimal harm to the resident) 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: ULP-B ULP-B was hired on November 10, 2021, as a resident assistant. On August 5, 2025, at 8:30 a.m., the surveyor arrived at the facility and was greeted by ULP-B. ULP-B was the only staff present at the facility when the surveyor arrived. On August 5, 2025, at 8:44 a.m., the surveyor observed ULP-B preparing to assist R2 with medication administration. No additional staff were present while ULP-B proceeded to attempt to assist R2, who refused the medication. ULP-B's employee record lacked evidence of a cleared DHS background study as required prior to providing services for the licensee's residents. A-C A-C began providing assisted living services on August 1, 2021. The licensee's DHS NETStudy 2.0 background study roster for HFID 36036, accessed August 6, 2025, at 11:30 a.m., did not include A-C. The DHS NETStudy 2.0 database indicated A-C had a cleared background study affiliated with another HFID owned by the same owner as the surveyed HFID, 36036.	01290		

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01290	Continued From page 32 A-C's employee record lacked evidence of a cleared DHS background study, affiliated with the surveyed HFID, 36036, prior to providing assisted living services for residents. On August 6, 2025, at 11:45 a.m., A-C stated they would not provide direct care to residents but had access to clinical records and employee records. A-C stated they would come to the facility if they needed to fix something or bring supplies. On August 6, 2025, at 11:51 a.m., A-C stated they were not aware they needed a background study. A-C stated they were aware they needed to redo the Covid-19 background studies as they had received notifications, but they recalled ULP-B was not on the list. The licensee's undated Employment Process policy indicated a criminal background study would be completed on all employees who provide direct care. The policy indicated employees may not work with residents until the background study had been received. The policy referenced 144A home care statue and not 144G for assisted living statue. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01530 SS=F	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:	01530		

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01530	Continued From page 33 (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 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;	01530		

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01530	Continued From page 34 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 two of three employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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-A was hired June 11, 2024, and provided direct cares and services for residents of the facility. ULP-B was hired November 21, 2021, and provided direct cares and services for residents of the facility. ULP-A and ULP-B's employee records lacked the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2025. On August 6, 2025, at 2:53 p.m., clinical nurse supervisor (CNS)-D stated the employees noted above lacked the required two (2) hours of initial training on mental illness and de-escalation. CNS-D further stated there had been nursing	01530		

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01530	Continued From page 35 turnover and ULP-A and ULP-B were hired prior to his hire date. In addition, CNS-D stated they were the nurse responsible to ensure staff training was completed timely and was going to include staff training in licensee's processes moving forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650		

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01650	Continued From page 36 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee on May 19, 2021. R2's Service Plan dated April 8, 2025, indicated R2 received assistance with medication administration. The service plan lacked a contingency plan that included the action to be taken if the scheduled service cannot be provided; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

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01650	Continued From page 37 authority to sign for the resident in an emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3 was admitted to the licensee on February 16, 2025. R3's Service Plan dated February 17, 2025, indicated R3 received assistance with medication management and medication set up. The service plan lacked a description of the fees for services; and a contingency plan that included the action to be taken if the scheduled service cannot be provided. On August 7, 2025, at 12:40 p.m., clinical nurse supervisor (CNS)-D stated they were familiar with the service plan, but it was an oversight for the missing content. CNS-D stated they will review the service plans. The licensee's undated Service Plan policy indicated the service plan would include the fees for services, and a contingency plan that included the action to be taken if the scheduled service cannot be provided; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident	01650		

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01650	Continued From page 38 under those chapters. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident	01910		

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01910	Continued From page 39 (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on February 1, 2024, and discharged on June 30, 2024. R1's Assisted Living Service Plan dated January 23, 2024, indicated R1 received medication management, medication set-up, and medication assistance. R1's medication administration record (MAR) dated June 2024, indicated R1 had last received assistance with medication administration on June 29, 2024. R1's record lacked a disposition of medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 5, 2025, at 10:43 a.m., agent (A)-C stated R1 had left the facility to live with family without any notification to the licensee. A-C stated R1's case manager had attempted to get R1 to return to the facility over a period of a few	01910		

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01910	Continued From page 40 months after they left but R1 had continued to refuse to return as they wanted to live with family. On August 6, 2025, at 2:45 p.m., agent (A)-C stated R1's medical record lacked a discharge summary and documentation of medication disposal. A-C further stated the registered nurse (RN) responsible for the completion of the documentation was no longer employed with the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		

Electronically Delivered

September 23, 2025

Licensee
Elite Nursing Services Inc
3100 Thurber Road
Brooklyn Center, MN 55430

RE: Project Number(s) SL36036016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 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.

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 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - $1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $3,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $7,000.00**. 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,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL36036016-0 On August 4, 2025, through August 7, 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 two residents receiving services under the Assisted Living Facility license. An immediate correction order was identified on August 5, 2025, issued for SL36036016-0, tag identification 0775. An immediate correction order was identified on August 6, 2025, issued for SL36036016-0, tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk related to tag identification 1290. Noncompliance	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.	

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	36036	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

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0 000	Continued From page 1 remained and the scope and level remain unchanged. An immediate correction order was identified on August 6, 2025, issued for SL36036016-0, tag identification 0495. During the course of the survey, the licensee failed to take action to mitigate the imminent risk related to tag identification 0495. The correction order for tag identification numbers 0495 and 1290 contain updated language in the scope and severity level statement at the beginning of the orders, reflecting changes that went into effect July 1, 2025.	0 000		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors.	0 110		

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0 110	Continued From page 2 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 4, 2025, at 7:57 a.m., the BELTSS website indicated the health facility identification number (HFID) 36036 had LALD-G listed as the residency permit director, but this had ended on October 15, 2024. The website did not list another LALD as the director of record for the licensee's HFID. On August 4, 2025, at 10:19 a.m., unlicensed personnel (ULP)-A stated LALD-G still worked for the licensee but stated they had not been to the facility for a while. The surveyor asked ULP-A for an approximate date for the last time they saw LALD-G. ULP-A had a long pause before stating it was the previous week and stated LALD-G would come and go to the facility. On August 4, 2025, at 10:21 a.m., agent (A)-C stated the licensee recently hired LALD-F as the licensee's LALD. On August 4, 2025, at 10:44 a.m., A-C confirmed LALD-G had no longer worked for the licensee. LALD-F was hired by the licensee on July 21, 2025, as the LALD. On August 4, 2025, at 1:01 p.m., the BELTSS	0 110		

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0 110	Continued From page 3 website indicated LALD-F was issued a license on June 25, 2021, with an expiration date of October 31, 2025. The BELTSS website did not indicate LALD-F was the director of record for the licensee's HFID 36036. On August 7, 2025, at 11:43 a.m., LALD-F stated they were in the active process of adding them as director of record for the licensee at the time of the surveyor interview. LALD-F stated they were not aware they needed to add themselves as the director of record upon hire and stated they were within a window to also renew their LALD license through BELTSS. The licensee's undated Assisted Living Director policy indicated the licensee expected the LALD to comply with all requirements set forth by BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies	0 470		

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0 470	Continued From page 4 and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the staffing plan was developed and reviewed by the clinical nurse supervisor (CNS) as required per Minnesota Administrative Rules 4659.0180. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 470		

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0 470	Continued From page 5 The licensee did not have a written staffing plan with all the required content developed by a CNS. On August 4, 2025, at 11:35 a.m., CNS-D stated they did not think they had developed a staffing plan recently and had asked the surveyor if they needed to create a staffing plan. Agent (A)-C stated they agreed with CNS-D and stated the staffing plan was something they had not done. On August 6, 2025, at 3:29 p.m., A-C and CNS-D confirmed the licensee did not have a staffing plan written. CNS-D stated they were not aware of the need but would create a staffing plan with all the required content. The licensee's undated Staffing & Scheduling policy indicated the CNS would develop and implement a written staffing plan. The policy referenced Minnesota Administrative Rule 4659.0180, subpart 3 and subpart 4. The policy did not indicate the staffing plan needed to include an evaluation to be conducted at least twice a year. Minnesota Administrative Rule 4659.0180, subpart 3, dated August 11, 2021, indicated a clinical nurse supervisor must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 6	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 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;	0 480		

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0 480	Continued From page 7 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 4, 2025, for the specific	0 480		

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0 480	Continued From page 8 Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer to provide or make available at least three nutritious meals daily according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines; failed to ensure a menu was prepared a week in advance and provided to the residents; and failed to ensure	0 485		

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0 485	Continued From page 9 the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living monthly base fee for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: MEAL AND MENU AVAILABILITY The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated January 7, 2025, indicated the licensee would have available three meals plus snacks as required. On August 4, 2025, at 12:02 a.m., agent (A)-C stated the licensee currently did not provide a menu to residents. A-C stated the licensee's current residents were to provide their own raw food per their choice. A-C stated the licensee currently only provided their residents with meal preparation based on the request from the resident. A-C sated if the resident did not provide the raw food to prepare for them, then the license would use the money paid for the service of meal preparation to pay for their raw food for the next meal. On August 4, 2025, at 2:07 p.m., resident (R3) stated they were told by their CADI worker it was R3's responsibility to buy their own raw food. R3 stated they have always had their meals provided	0 485		

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0 485	Continued From page 10 at other assisted living facilities but did not know why it was different at the current facility. R3 stated not having meals provided affected their mental health as they had never had to deal with purchasing their own food. R3 stated the facility had provided meals everyday but had worried the facility could stop at any time. CONTRACTS R2 R2 was admitted to the licensee on May 19, 2021. R2's Resident Contract for Assisted Living dated February 1, 2024, indicated all services listed on Attachment A were included in the monthly base fee. Attachment A included at least three meals daily with snacks available seven days per week. R3 R3 was admitted to the licensee on February 16, 2025. R3's Resident Contract for Assisted Living dated February 16, 2025, indicated all services listed on Attachment A were included in the monthly base fee. Attachment A included at least three meals daily with snacks available seven days per week. The licensee's undated Assisted Living Contracts policy indicated the minimum requirements for assisted living require three meals and snacks must be made available, and the facility could not require a resident to include and pay for meals in their contract. No further information was provided.	0 485		

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0 485	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff and residents had access to a registered nurse (RN) on-call 24-hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee began providing assisted living services on August 1, 2021. At the time of the survey, the licensee had two residents, R2 and R3. Both residents received assisted living services. R2's service plan dated April 8, 2025, indicated R2 received services including daily assistance with medication administration.	0 495	The licensee failed to submit a plan of correction; the scope and severity remain at level 3, widespread.	

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0 495	Continued From page 12 On August 5, 2025, at 8:44 a.m., the surveyor observed ULP-B preparing to assist R2 with medication administration. ULP-B proceeded to attempt to assist R2, who refused the medication. Clinical nurse supervisor (CNS)-D was hired by the licensee on July 9, 2025, to perform all nursing tasks. On August 4, 2025, at 10:21 a.m., agent (A)-C stated CNS-D worked for the licensee part time and was the only nurse at the facility. A-C stated CNS-D also worked for a home care agency and had a job at a hospital. On August 4, 2025, at 10:29 a.m., during the entrance conference, CNS-D stated they worked 32 hours per week at a hospital in the trauma neuro-intensive care unit (ICU). On August 5, 2025, at 8:50 a.m., unlicensed personnel (ULP)-B stated when the nurse was working at their other job, it would take 10 or 15 minutes for the nurse to call back but once in a while the ULP did not get a response for the entire day, and in that situation, they would call A-C and A-C (who was not a RN) would help them. On August 6, 2025, at 2:12 p.m., CNS-D stated they worked at the hospital in the ICU for critically ill patients. CNS-D stated they provided medication administration, worked with respiratory therapists, and managed patients' ventilators. CNS-D stated they were the charge nurse on the unit, but some shifts they would provide the direct cares and work one on one with the patient, if needed. CNS-D stated they	0 495		

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0 495	Continued From page 13 could not recall a time when staff had tried to reach them, and they were not able to get back to the staff. The licensee's Availability of an RN Staff policy dated January 2024, indicated the RN must be readily available either in person, by telephone, or by other means to the staff at all times when the staff provided services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 650 SS=F	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	0 650		

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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
0 650	Continued From page 14 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-A, ULP-B, clinical nurse supervisor (CNS)-D). 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: ULP-A ULP-A was hired by the licensee on June 11, 2024. ULP-A's employee record lacked evidence of completed annual performance review for 2025. ULP-B ULP-B was hired by the licensee on November 10, 2021. ULP-B's employee record lacked evidence of completed annual performance review for 2023 and 2022. CNS-D	0 650		

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	36036	A. BUILDING: _____ B. WING _____	08/07/2025

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0 650	Continued From page 15 CNS-D was hired by the licensee on July 9, 2024. CNS-D's employee record lacked evidence of completed annual performance review for 2025. On August 5, 2025, at 10:25 a.m., agent (A)-C stated the performance reviews should be done annually. A-C stated they were not sure if ULP-B's performance review for 2025 were completed yet. On August 6, 2025, at 1:46 p.m., A-C stated licensee ULP-A's annual performance review was due; however, it had not been completed yet. In addition, CNS-D's review had not been completed because they did not have anyone to complete nurse reviews. The licensee's undated Personnel Records policy indicated the personnel record for an employee shall include an annual performance evaluation that identified areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 16 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment and baseline TB Health screening for one of two employees (unlicensed personnel (ULP)-A). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: FACILITY TB RISK ASSESSMENT The licensee's Facility TB Risk Assessment dated June 2021, was completed on January 23,	0 660		

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0 660	Continued From page 17 2024. The assessment identified the national rate was 2.2 percent and the Minnesota rate was 2.1 percent for 2020. The assessment form and data used to complete the incidence of TB was not current information at the time the assessment was completed. Also, the assessment was blank under the following areas of the assessment: TB screening of health care personnel; TB screening of patients; infection control plan; TB training plan; and quality improvement. On August 4, 2025, at 11:47 a.m., clinical nurse supervisor (CNS)-D stated they were not very familiar with the Facility Tuberculosis (TB) Risk Assessment. Agent (A)-C stated the Facility TB Risk Assessment had been completed a little over a year ago prior to CNS-D's employment with the licensee. ULP-A ULP-A was hired June 11, 2024, and provided direct cares and services for residents of the facility. ULP-A's employee file included a negative TB QuantiFERON Gold Plus (blood test) dated April 10, 2024; however, lacked a baseline TB history and symptom screen. On August 6, 2025, at 1:46 p.m., agent (A)-C stated ULP-A's employee file lacked TB baseline screening upon hire. A-C further stated the registered nurse (RN) was responsible to ensure TB screening and testing was completed at time of hire. Moreover, A-C stated he would complete employee file reviews and considered the missing documentation an oversite on his part. The licensee's undated Tuberculosis Screening	0 660		

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0 660	Continued From page 18 policy indicated each employee or volunteer having direct contact with residents would have documentation of baseline health symptom screening prior to providing care to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP updated January 2024, lacked evidence of the following required content: - maintain and annual EP updates; - EP program patient population; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - development of communication plan; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - LTC (long term care) family notifications. On August 6, 2025, at 8:58 a.m., during a review of the facility's EPP with agent (A)-C, A-C stated	0 680		

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0 680	Continued From page 20 they were not aware the licensee needed to review the missing resident plan quarterly. The licensee's EPP did not have their delegations of authority updated as the licensee's EPP had previous employees who were no longer employed by the licensee. A-C confirmed the licensee did not have any policies and procedures for at minimum food, water, and pharmaceutical supplies; alternate sources of energy; sewage/waste disposal; sheltering; tracking of staff and residents during an emergency; sheltering, medical documents; use of volunteers; and the role of facility under a waiver declared by the secretary; and methods for sharing information. A-C confirmed the licensee did not have any arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents. The licensee's communication plan was not completed and had blank areas within the communication plan. On August 6, 2025, at 10:26 a.m., A-C confirmed the EPP was missing required content and would work on the missing content for the facility's EPP. The licensee's undated Emergency Management policy indicated the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. The policy did not reference the facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z. No additional information was provided.	0 680		

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0 680	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (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; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (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; (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;	0 730		

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0 730	Continued From page 22 (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident's record included a discharge summary for one of one discharged 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on February 1, 2024, and discharged on June 30, 2024. R1's record lacked a discharge summary. On August 5, 2025, at 10:43 a.m., agent (A)-C	0 730		

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0 730	Continued From page 23 stated R1 had left the facility to live with family without any notification to the licensee. A-C stated R1's case manager had attempted to get R1 to return to the facility over a period of a few months after they left but R1 had continued to refuse to return as they wanted to live with family. On August 6, 2025, at 2:45 p.m., agent (A)-C stated R1's medical record lacked a discharge summary and documentation of medication disposal. A-C further stated the registered nurse (RN) responsible for the completion of the documentation was no longer employed with the licensee. The licensee's undated Resident Records policy indicated the contents of a resident record would include a discharge summary. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code. The deficient condition has the ability to affect all staff and residents.	0 775		

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0 775	Continued From page 24 This practice resulted in a level four violation (a violation harmed a client's/resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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 clients/residents). The findings include: On a facility tour on August 5, 2025, between 9:00 a.m. and 11:30 a.m. with agent (A)-C the surveyor observed that compliant emergency escape rescue openings were not provided in resident rooms. Upper-level resident room 3 emergency escape and rescue clear window opening measurements are 18" wide x 37" high. Based on an exterior observation, the window in resident room 1 appeared to be same size as the window in resident room 3, but exact measurements could not be verified due to the surveyor not being given access to the room during the survey by the provider. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum clear opening dimension of 20 inches in height and a minimum clear opening dimension of 20 inches in width with at least one compliant emergency escape and rescue opening required within each resident sleeping room. Measurements were taken by the surveyor with A-C present and observing. These deficient conditions were visually verified by A-C accompanying on the tour. The surveyor	0 775		

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0 775	Continued From page 25 explained that an immediate correction order will be issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. Additionally on facility tour on August 5, 2025, between 9:00 a.m. and 12:30 p.m. with agent (A)-C the surveyor observed the following conditions: EXTENSION CORD: The surveyor observed that a electrical extension cord was being used in the kitchen and was permanently affixed to structure. Electrical extension cords shall not be used for permanent use and be affixed to the structure. SMOKE ALARMS: The surveyor observed that there was not a smoke alarm present inside resident room 2, 3 and 4. Provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms, 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. OXYGEN STORAGE: The surveyor observed cylinders of oxygen in the garage that were not stored securely and leaning over and laying on the ground.	0 775		

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0 775	Continued From page 26 All oxygen cylinders shall be stored securely. The deficient conditions were visually verified by A-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=I	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 27 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. The deficient condition has the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a client's/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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 clients/residents). The findings include: On facility tour with administrator (A)-C on August 5, 2025, between 9:00 a.m. and 12:30 p.m. the following deficient condition was observed: SMOKE ALARMS: The A-C checked the interconnection of the smoke alarms and the other smoke alarms in the facility did not operate when tested. All smoke alarms in the facility shall be interconnected. The deficient condition was visually verified by the A-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 780		

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0 780	Continued From page 28 days.	0 780		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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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
0 810	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document required fire safety evacuation training for employees and residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a client's/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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 clients/residents). The findings include: A record review and interview were conducted on August 5, 2025, at approximately 12:00 p.m. with the administrator (A)-C on the fire safety and evacuation plan training records for the employees and the residents. TRAINING: The A-C confirmed that they had not documented training on the fire safety and evacuation plan for the employees or residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36036	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

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01290	Continued From page 30 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. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to obtain a cleared Department of Human Services (DHS) background study prior to staff providing services for one of seven employees (unlicensed personnel (ULP)-B). Further the licensee failed to obtain a DHS background study affiliated with the licensee's health facility identification (HFID) for one of seven employees (agent (A)-C). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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).	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 31 The findings include: ULP-B ULP-B was hired on November 10, 2021, as a resident assistant. On August 5, 2025, at 8:30 a.m., the surveyor arrived at the facility and was greeted by ULP-B. ULP-B was the only staff present at the facility when the surveyor arrived. On August 5, 2025, at 8:44 a.m., the surveyor observed ULP-B preparing to assist R2 with medication administration. No additional staff were present while ULP-B proceeded to attempt to assist R2, who refused the medication. ULP-B's employee record lacked evidence of a cleared DHS background study as required prior to providing services for the licensee's residents. A-C A-C began providing assisted living services on August 1, 2021. The licensee's DHS NETStudy 2.0 background study roster for HFID 36036, accessed August 6, 2025, at 11:30 a.m., did not include A-C. The DHS NETStudy 2.0 database indicated A-C had a cleared background study affiliated with another HFID owned by the same owner as the surveyed HFID, 36036. A-C's employee record lacked evidence of a cleared DHS background study, affiliated with the surveyed HFID, 36036, prior to providing assisted living services for residents.	01290		

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	36036	A. BUILDING: _____ B. WING _____	08/07/2025

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ELITE NURSING SERVICES INC	3100 THURBER ROAD BROOKLYN CENTER, MN 55430

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01290	Continued From page 32 On August 6, 2025, at 11:45 a.m., A-C stated they would not provide direct care to residents but had access to clinical records and employee records. A-C stated they would come to the facility if they needed to fix something or bring supplies. On August 6, 2025, at 11:51 a.m., A-C stated they were not aware they needed a background study. A-C stated they were aware they needed to redo the Covid-19 background studies as they had received notifications, but they recalled ULP-B was not on the list. The licensee's undated Employment Process policy indicated a criminal background study would be completed on all employees who provide direct care. The policy indicated employees may not work with residents until the background study had been received. The policy referenced 144A home care statue and not 144G for assisted living statue. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01530 SS=F	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	01530		

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	36036	A. BUILDING: _____ B. WING _____	08/07/2025

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01530	Continued From page 33 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 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	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36036	A. BUILDING: _____ B. WING _____	08/07/2025

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01530	Continued From page 34 hours of start date for two of three employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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-A was hired June 11, 2024, and provided direct cares and services for residents of the facility. ULP-B was hired November 21, 2021, and provided direct cares and services for residents of the facility. ULP-A and ULP-B's employee records lacked the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2025. On August 6, 2025, at 2:53 p.m., clinical nurse supervisor (CNS)-D stated the employees noted above lacked the required two (2) hours of initial training on mental illness and de-escalation. CNS-D further stated there had been nursing turnover and ULP-A and ULP-B were hired prior to his hire date. In addition, CNS-D stated they were the nurse responsible to ensure staff training was completed timely and was going to include staff training in licensee's processes moving forward.	01530		

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01530	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 36 by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee on May 19, 2021. R2's Service Plan dated April 8, 2025, indicated R2 received assistance with medication administration. The service plan lacked a contingency plan that included the action to be taken if the scheduled service cannot be provided; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 37 R3 R3 was admitted to the licensee on February 16, 2025. R3's Service Plan dated February 17, 2025, indicated R3 received assistance with medication management and medication set up. The service plan lacked a description of the fees for services; and a contingency plan that included the action to be taken if the scheduled service cannot be provided. On August 7, 2025, at 12:40 p.m., clinical nurse supervisor (CNS)-D stated they were familiar with the service plan, but it was an oversight for the missing content. CNS-D stated they will review the service plans. The licensee's undated Service Plan policy indicated the service plan would include the fees for services, and a contingency plan that included the action to be taken if the scheduled service cannot be provided; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged 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 an isolated scope (when one or a	01910		

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01910	Continued From page 39 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on February 1, 2024, and discharged on June 30, 2024. R1's Assisted Living Service Plan dated January 23, 2024, indicated R1 received medication management, medication set-up, and medication assistance. R1's medication administration record (MAR) dated June 2024, indicated R1 had last received assistance with medication administration on June 29, 2024. R1's record lacked a disposition of medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 5, 2025, at 10:43 a.m., agent (A)-C stated R1 had left the facility to live with family without any notification to the licensee. A-C stated R1's case manager had attempted to get R1 to return to the facility over a period of a few months after they left but R1 had continued to refuse to return as they wanted to live with family. On August 6, 2025, at 2:45 p.m., agent (A)-C stated R1's medical record lacked a discharge summary and documentation of medication disposal. A-C further stated the registered nurse (RN) responsible for the completion of the	01910		

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01910	Continued From page 40 documentation was no longer employed with the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		

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

ELITE NURSING SERVICES INC
3100 THURBER ROAD
Brooklyn Park, MN 55430
Parcel:

Phone:

License Info

License: HFID 36036

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

Inspection Info

Report Number: F1013251047
Inspection Type: Full - Single
Date: 8/4/2025 Time: 01:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 4
Total Priority 3 Orders: 1
Delivery:

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: 8/4/25 REPEAT
NO MN CFPM WAS EMPLOYED AT THE FACILITY. A CURRENT SERV SAFE CERTIFICATE WAS POSTED. COMPLY WITH RULE. MN CFPM INFORMATION WAS PROVIDED. ORDER WAS ISSUED ON 10/17/23.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: 8/4/25 REPEAT
NO ILLNESS LOG WAS MAINTAINED OR AVAILABLE. COMPLY WITH RULE. DISCUSSED STAFF ILLNESS POLICY AND THE MDH TEMPLATE WAS PROVIDED. ORDER WAS ISSUED ON 10/17/23.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

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: OPEN PACKAGES OF READY-TO-EAT DELI MEAT WERE INSIDE THE KITCHEN REFRIGERATOR. THE MANUFACTURER'S USE BY DATE WAS APRIL 2025. COMPLY WITH RULE. FOOD WAS DISCARDED.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: TCS FOODS ARE STORED ONSITE. NO FOOD PROBE THERMOMETER WAS AVAILABLE. COMPLY WITH RULE. DISCUSSED THERMOMETER USE WITH STAFF.
Comply By: 8/8/2025 Originally Issued On: 8/4/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: 8/4/25 REPEAT
RESIDENTIAL HOT WATER SANITIZING DISH MACHINE IS USED. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH RULE. ORDER WAS ISSUED ON 10/17/23.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: 8/4/25 REPEAT
FACILITY USES CHLORINE SANITIZER. NO CHLORINE TEST KIT WAS AVAILABLE. COMPLY WITH RULE. ORDER WAS ISSUED ON 10/17/23.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator R. Quinehan.

The establishment has a residential kitchen and serves food from restaurants. Per the operator no food preparation is completed by staff onsite. The kitchen has wood cabinets, tile floor, tile walls, solid counter top, and a smooth painted ceiling.

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

Residential dish machine is available for ware washing.

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

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

I acknowledge receipt of the Metro District Office inspection report number F1013251047 from 8/4/2025

Jerry Malloy

Trobel Garsinii
Operator

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

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

Temperature Observations/Recordings

Establishment Info

ELITE NURSING SERVICES INC
Brooklyn Park
County/Group:

Inspection Info

Report Number: F1013251047
Inspection Type: Full
Date: 8/4/2025
Time: 01:00 PM

Food Temperature: Product/Item/Unit: Deli meat**; Temperature Process:** Cold-Holding
Location: Refrigerator 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

ELITE NURSING SERVICES INC
Brooklyn Park
County/Group:

Inspection Info

Report Number: F1013251047
Inspection Type: Full
Date: 8/4/2025
Time: 01:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No