Electronically Delivered

September 17, 2026

Licensee
Temple Hill Inc.
2942 Oliver Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL37390016

Dear Licensee:

On August 26, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 4, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

Electronically Delivered

June 30, 2026

Licensee
Temple Hill Inc.
2942 Oliver Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL37390016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - $1,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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.

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	37390	A. BUILDING: _____ B. WING _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEMPLE HILL INC.	2942 OLIVER AVENUE NORTH MINNEAPOLIS, MN 55411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37390016-0 On June 1, 2026, through June 4, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license. An immediate correction order was identified on June 3, 2026, issued for SL37390016-0, tag identification 0495. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470		

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 3, 2026, at 1:22 p.m., agent (A)-B sent the licensee's staffing plan to the surveyor via email communication. The staffing plan indicated A-B had prepared it. The plan contained no documentation of the date the plan was developed and lacked documentation to show the clinical nurse supervisor (CNS) had taken part in the development. On June 3, 2026, at 1:52 p.m., CNS-C stated A-B did the staffing plan. CNS-C stated that since the change of ownership had taken place, they had not had any role in the development of a staffing plan and were not aware the staffing plan needed to be developed by the CNS. On June 4, 2026, at 9:41 a.m., A-B stated CNS-C had taken part in the development of the staffing plan, and was not sure as to why they said they had not. Assisted Living Facilities: Minnesota Rules Chapter 4659.0160 Subpart 3., indicates, "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.	0 470		

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0 470	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 observation, interview, and record review, the licensee failed to provide staff access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This had the potential to affect all residents and staff. 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: On June 1, 2026, during the survey, the licensee had a census of two residents. The licensee's Staff List dated June 1, 2026, indicated clinical nurse supervisor (CNS)-C was hired on May 21, 2025. R2 R2 was admitted to the licensee on November 26, 2022, to receive assisted living services.	0 495		

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0 495	Continued From page 4 R2's diagnoses included paranoid schizophrenia. R2's Service Plan dated January 1, 2026, indicated R2 received assisted living services to include activity assistance, bedmaking, grooming, housekeeping, incontinence care, laundry, linen changes, behavior management, meal assistance, medication administration, medication setup, vital signs, and safety checks. R2's medications list dated current as of June 3, 2026, indicated R2 received Amlodipine (blood pressure medication), carvedilol (blood pressure medication), Eliquis (blood thinning medication, increases risk of bleeding), Incruse Ellipta (inhaler medications for improving breathing), Risperdal Consta 50mg injection (antipsychotic medication inject every 2 weeks), risperidone (antipsychotic medication), and rosuvastatin (reduces cholesterol). R2's Individual Abuse Prevention Plan dated April 3, 2026, indicated R2 was a fall risk and was at risk to be abused physically and financially. On June 2, 2026, at 8:26 a.m., the surveyor observed R2 receiving medications administered by unlicensed personnel (ULP)-E. R3 R3 was admitted to the licensee on September 9, 2024, to receive assisted living services. R3's diagnoses included schizoaffective disorder, acute necrotizing encephalopathy, acute on chronic congestive heart failure, alcohol abuse, anemia, angina pectoris, cervical disc disorder, type two diabetes, aphasia, hypertension, nontraumatic acute subdural hemorrhage, and chronic obstructive pulmonary disease.	0 495		

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0 495	Continued From page 5 R3's Service Plan dated January 1, 2026, indicated R3 received assisted living services to include activity assistance, bedmaking, grooming, housekeeping, incontinence care, laundry, linen changes, behavior management, meal assistance, medication administration, medication setup, vital signs, and safety checks. R3's medications list dated current as of June 3, 2026, indicated R3 received Carvedilol (blood pressure medication), furosemide (reduces fluid retention and may increase risk of falls), losartan (blood pressure medications), quetiapine (antipsychotic), sertraline (antidepressant), and trazodone (for treatment of depression and anxiety). R3's Individual Abuse Prevention Plan dated April 2, 2026, indicated R3 exhibited resistance to taking medications, required nurse instruction when medication changes occurred, and was at risk of falls. On June 1, 2026, at 10:32 a.m., during the entrance conference CNS-C stated they were onsite at the facility around one day a week. CNS-C stated they currently worked at Region's hospital as a 0.6 FTE, or 48 hours every two weeks within the hospital's mental health unit and they sometimes picked up extra shifts. CNS-C stated they were unable to carry their personal phone on them while on the unit and their phone was stored within the hospital's employee locker room area. On June 3, 2026, at 1:38 p.m., CNS-C again stated the unit they worked on was a secured unit and they were not allowed easy access to their personal phone. CNS-C stated in the event of	0 495		

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0 495	Continued From page 6 facility staff needing them, staff would leave a message, and they would respond when they had down time and in the event of an emergency, staff would be expected to send residents to the emergency room. The licensee's On-Call Policy dated January 1, 2026, indicated a registered nurse will be available in person or by phone at all times when staff is providing services to residents and respond to concerns from residents and residents' representatives. The facility will make adequate provisions to ensure that RN coverage is available at all times whenever staff is providing services, including when regular nursing staff is off duty, on vacation or on sick leave. Minnesota Statute 144G.62 Subdivision 1. (a) indicated assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks, and (b) the appropriate contact person must be readily available either in person, by telephone or other means to the staff at times when the staff are providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
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 7 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 observation, interview, and record review, the licensee failed to maintain written evidence of 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 documentation of TB history and symptom for three of three employees (agent (A)-B, clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's facility TB risk assessment dated January 5, 2026, indicated the facility had a low risk. A-B	0 660		

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0 660	Continued From page 8 A-B was hired on January 26, 2026, to provide assisted living services and administrative oversite. On June 1, 2026, from 10:18 a.m. to 2:45 p.m., the surveyor observed A-B onsite within the facility and directly interacting with residents. On June 1, 2026, at 11:08 a.m., A-B stated they worked full-time onsite within the facility and covered open direct-care shifts as needed. A-B's employee record contained a QuantiFERON-TB Gold Plus test dated April 15, 2026, which indicated postive results for tuberculosis, and a chest x-ray dated April 28, 2026, that indicated negative results for active tuberculosis. CNS-C CNS-C was hired on May 21, 2025, to provide assisted living services and clinical oversite. On June 1, 2026, from 10:18 a.m. to 2:45 p.m., the surveyor observed CNS-C onsite within the facility and directly interacting with residents. CNS-C's employee record contained a QuantiFERON TB gold test dated June 26, 2025, which indicated negative results. ULP-E ULP-E was hired on July 15, 2023, to provide assisted living services. ULP-E's employee record contained a QuantiFERON-TB Gold Plus test dated July 17, 2023, which indicated postive results for tuberculosis, and a chest x-ray dated February 11, 2026, that indicated negative results for active	0 660		

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0 660	Continued From page 9 tuberculosis. On June 2, 2026, from 8:07 a.m. to 8:29 a.m., the surveyor observed ULP-E administer medications to residents residing within the facility. A-B, CNS-C, and ULP-E's employee records lacked documentation of TB history and symptom screening. On June 3, 2026 at 1:24 p.m., CNS-C stated they recalled completing the forms for staff and were not sure as to why the documents were not retained for the employee records. The licensee's Tuberculosis Screening policy dated January 1, 2026, indicated each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employees' record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents under the assisted living facility license. This practice resulted in a level two violation (a	0 680		

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TEMPLE HILL INC.	2942 OLIVER AVENUE NORTH MINNEAPOLIS, MN 55411

(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 11 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: On June 1, 2026, at 11:20 a.m., the surveyor observed licensed assisted living director (LALD)-D retrieve the licensee's EPP from the locked filing cabinet. The licensee's undated EPP was found within a binder titled "survey binder" and was not clearly labeled as containing an EPP. The EPP lacked evidence of the following required content: - policies and procedures regarding subsistence needs for staff and residents; - policies and procedures for evacuation; - policies and procedures for sheltering; - policies and procedures for medical documentation; - documentation of arrangements with other facilities; - emergency official contact information; and - methods for sharing information. On June 4, 2026, at 9:42 a.m., agent (A)-B stated they had worked in conjunction with LALD-D on the development of the EPP and was unaware of its current deficits. The licensee's Emergency Management policy dated January 1, 2026, indicated the facility would have an identified plan in place to ensure the safety and well-being of residents.	0 680		

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0 680	Continued From page 12 Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 13 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 810		

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0 810	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 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	01530		

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01530	Continued From page 15 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 observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within 160 working hours of employment for direct care staff and within 120 working hours for supervisors of direct-care staff as required for two of three employees (agent (A)-B, clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: A-B A-B was hired on January 26, 2026, to provide assisted living services and administrative oversite. A-B's employee record indicated 5.75 hours of the required eight hours of dementia care training had been completed.	01530		

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01530	Continued From page 16 On June 1, 2026, from 10:18 a.m. to 2:45 p.m., the surveyor observed A-B onsite within the facility and directly interacting with residents. On June 1, 2026, at 11:08 a.m., A-B stated they worked full-time onsite within the facility and covered open direct-care shifts as needed. CNS-C CNS-C was hired on May 21, 2025, to provide assisted living services and clinical oversite. CNS-C's employee record indicated seven of the required eight hours of dementia care training had been completed. On June 1, 2026, from 10:18 a.m. to 2:45 p.m., the surveyor observed CNS-C onsite within the facility and directly interacting with residents. On June 1, 2026, at 10:32 a.m., CNS-C stated they typically worked onsite with the licensee one day per week and was on call with the licensee 24/7 after that. On June 3, 2026, at 1:27 p.m., CNS-C stated they were not aware of the required eight hours of dementia training. CNS-C stated A-B was typically responsible for auditing staff records for compliance. On June 4, 2026, at 9:47 a.m., A-B stated they were responsible for assigning trainings to staff but was unaware of the missing training items. The licensee's Dementia Care Training policy date January 1, 2026, indicated supervisors of direct-care staff must have at least eight hours of initial training within 120 working hours of	01530		

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01530	Continued From page 17 employment start date and direct care staff must have at least eight hours of initial training within 160 hours employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=F	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	01650		

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01650	Continued From page 18 chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of four 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on November 26, 2022, to receive assisted living services. R2's diagnoses included paranoid schizophrenia. R2's Service Plan dated January 1, 2026, indicated R2 received activity assistance, bedmaking, grooming, housekeeping, incontinence care, laundry, linen changes, behavior management, meal assistance, medication administration, medication setup, vital signs, and safety checks. On June 2, 2026 at 8:18 a.m., the surveyor observed ULP-E provide R2 with medication administration. R3	01650		

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01650	Continued From page 19 R3 was admitted to the licensee on September 9, 2024, to receive assisted living services. R3's diagnoses included schizoaffective disorder, acute necrotizing encephalopathy, acute on chronic congestive heart failure, alcohol abuse, anemia, angina pectoris, cervical disc disorder, type two diabetes, aphasia, hypertension, nontraumatic acute subdural hemorrhage, and chronic obstructive pulmonary disease. R3's Service Plan dated January 1, 2026, indicated R3 received activity assistance, bedmaking, grooming, housekeeping, incontinence care, laundry, linen changes, behavior management, meal assistance, medication administration, medication setup, vital signs, and safety checks. R2 and R3's service plans lacked the following required content: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan that includes the action to be taken if the scheduled service cannot be provided, information and a method to contact the facility, 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 20 On June 2, at 9:50 a.m., agent (A)-B stated they had issued the service plans to R2 and R3 when the change of ownership had taken place on January 1, 2026, but they were not aware of the missing components. A-B stated they used a form called service plan modification generated by Residex (a medical records software system). A-B stated they were not aware the form lacked the required components. The licensee's Service Plan policy dated January 1, 2026, indicated service plans would include: - a description of the services to be provided; - the staff or categories of staff that will provide the services; - the type and frequency of visits/services proposed to be furnished according to the resident's current review/assessment and resident preferences; - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - the extent to which payment may be expected from a third-party payer; - the charges for services that will not be covered by a third-party payer; - the charges the individual may have to pay; and - a contingency plan for circumstances when services cannot be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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02290	Continued From page 21	02290		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee included language within the residency agreement contract and in house rules which limited the rights of all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3's contract signed on January 1, 2026, under the section titled Term and Termination indicated that reasons for contract termination may include "You are not abiding by the Rules and Regulations or are breaching any representation, covenant, agreement, or obligation of the resident under this Contract." On June 1, 2026, at 2:32 p.m., agent (A)-B stated the contract in R3's record was the same utilized by all residents.	02290		

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02290	Continued From page 22 On June 1, 2026, at 11:36 a.m., the surveyor observed the following postings located in multiple locations throughout the facility which contained language that had the potential to limit the rights of residents. The posting titled "House Rules- Reminder", included the following language which limited the rights of residents: "- No guest is allowed before 8AM. - No guest is allowed after 8PM and overnight. If they come to the facility after 8pm and they need anything from the client, please ask the guest to wait outside and call the client out for the guest. - No guest is allowed to open the refrigerator or use the facility stove to cook. The host/hostess should get his/her guests what they need. - Guests cannot use the bathroom to shower or sit unnecessarily long in the bathroom." The posting titled "Warning to all residents/Guests Rules- Reminder", included the following language which limited the rights of residents: "Smoking of weed (marijuana) in any form whether raw or as a vape material is prohibited in and around this facility. Please note that we have a zero tolerance for this or its possession in out facility. Doing this may lead to an immediate termination of your lease/housing here." The posting titled "Drug and Alcohol prohibition policy", included the following language which limited the rights of residents: "1. Zero tolerance for drugs or any drug paraphernalia at the facility. 2. No drug or alcohol permitted in the facility. 3. The use sale, manufacture, distribution or	02290		

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02290	Continued From page 23 possession of illegal drugs within or around our facility by the resident or any of our residents' guests is strictly prohibited. 4. Violation of this policy by you or any of your guests will result in terminating your service and your lease effective immediately." On June 3, 2026, at 1:38 p.m., clinical nurse supervisor (CNS)-C stated that the visiting hours posting has been enforced in the past with resident's visitors and they have also had to bar entrance into the facility of resident guests due to disruptive behaviors. On June 4, 2026, at 9:47 a.m., agent (A)-B stated they would be removing all house rules postings from the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R2).	02310		

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02310	Continued From page 24 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: On June 2, 2026, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-E retrieve R2's medications from the locked medication cabinet. The majority of R2's medications were kept in a pharmacy prepared comingled medication card, but some of R2's morning medications were kept in a plastic medication planner. ULP-E administered carvedilol 25 milligram (mg) tablet, amlodipine 10mg tablet, Eliquis 5mg tablet, and Tab-a-vite tablet from the pharmacy prepared comingled medication card and Senna from the plastic medication planner. On June 2, 2026, at approximately 8:20 a.m., agent (A)-B stated they had set up the medication planner for R2. A-B stated the medication planner contained R2's senna and was set up to make medication passes easier for staff. On June 3, 2026, at 1:31 p.m., clinical nurse supervisor (CNS)-C stated the medications in the plastic medication planner container were as needed medications that had been set up by agent (A)-B. CNS-C stated the medications had been set up as R2 frequently requested them. CNS-C stated they were not aware unlicensed personnel were not allowed to set up medication	02310		

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TEMPLE HILL INC.	2942 OLIVER AVENUE NORTH MINNEAPOLIS, MN 55411

(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
02310	Continued From page 25 planners for other unlicensed personnel to administer from. CNS-C stated they utilized a medication setup form when comleting medication cycle refills with the facility, but there was no documentation completed for the set up of R2's senna. Based on the National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

DEPARTMENT OF HEALTH

, MN
Phone:

Food & Beverage Inspection Report

Establishment Info

TEMPLE HILL INC
2942 OLIVER AVENUE NORTH
Mineapolis, MN 55411
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37390

Risk:
License:
Expires on:
CFPM: Adeleke Ijiyode
CFPM #: 58385; Exp: 4/14/2028

Inspection Info

Report Number: F1068261007
Inspection Type: Full - Joint
Date: 6/1/2026 Time: 12:00pm
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THE INSPECTION WAS COMPLETED AND DISCUSSED WITH THE PERSON IN CHARGE AND HEALTH REGULATION DIVISION NURSING EVALUATOR, ZACHARY MORTH (MDH).

THE ESTABLISHMENT HAS A RESIDENTIAL GRADE KITCHEN, INCLUDING THE REFRIGERATOR AND DISH MACHINE. THE KITCHEN FINISHES ARE AS FOLLOWS:

FLOORS: LINOLEUM TILE
WALLS: SMOOTH, PAINTED
CEILINGS: SMOOTH, PAINTED

THE ESTABLISHMENT HAS A PREDETERMINED, MEAL MENU FOR RESIDENTS. THE PERSON IN CHARGE STATED THAT MOST RESIDENTS MEALS ARE PREPARED ONSITE, BUT THAT RESIDENTS HAVE THE OPTION TO ORDER MEALS FROM "OPTAGE - SENIOR DINING CHOICES".

THE PERSON IN CHARGE STATED THAT ALL FOOD PREPARED FOR RESIDENTS IS KEPT NO LONGER THAN A DAY, USING SAME DAY SERVICE.

FOOD FOR RESIDENTS IS SOURCED FROM WALMART AND HYVEE.

THE FOLLOWING TOPICS WERE DISCUSSED DURING THE INSPECTION:
-HANDWASHING & DISPOSABLE GLOVE USE
-SANITIZATION CYCLE ON THE RESIDENTIAL DISH MACHINE
-SERVING A HIGHLY SUSCEPTIBLE POPULATION
-SAME DAY SERVICE
-BODILY FLUID CLEAN-UP PROCEDURES
-EMPLOYEE ILLNESS POLICY AND REPORTING PROCEDURES

THE FOLLOWING WERE NOT OBSERVED DURING THE INSPECTION:
-RESIDENTIAL DISH MACHINE FINAL RINSE TEMPERATURE
-EMPLOYEE ILLNESS LOG
-THIN DIAMETER PROBE THERMOMETER

THE PERSON IN CHARGE PROVIDED PICTURES OF THE UNOBSERVED ITEMS POST INSPECTION.

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 inspection report number F1068261007 from 6/1/2026

Gabriel Stark

Adeleke Ijiyode
Person in charge

Gabe Stark,
Public Health Sanitarian 2
gabe.stark@state.mn.us

, MN

DEPARTMENT OF HEALTH

Temperature Observations/Recordings

Establishment Info

TEMPLE HILL INC
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1068261007
Inspection Type: Full
Date: 6/1/2026
Time: 12:00pm

Food Temperature: Product/Item/Unit: MILK; **Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

, MN

Sanitizer Observations/Recordings

Establishment Info

TEMPLE HILL INC
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1068261007
Inspection Type: Full
Date: 6/1/2026
Time: 12:00pm

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37390016-0	**Date:** June 3, 2026
Facility Name: Temple Hill Inc	
Facility Address: 2942 Oliver Ave N. Minneapolis, MN 55411	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and P.A.S.S (Pull, Aim, Squeeze, and Sweep) but the plan was designed for a building with life safety systems such as sprinklers. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems.

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

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

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

   Comments: The licensee failed to provide evacuation training to residents at least once per year. Agent (A)-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the FSEP.

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

   Comments: A-B provided documentation that drills were completed on January 18, 2026, and April 20, 2026. No other drill documentation was provided for review during survey.