Assisted Living Facility Licensing

2026 Evaluation Report

Program Evaluation Division

Office of the Legislative Auditor

State of Minnesota

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Judy Randall, Legislative Auditor
State of Minnesota

September 2026

Members of the Legislative Audit Commission:

Assisted living facilities provide health care and housing to thousands of Minnesotans. The Minnesota Department of Health (MDH) licenses and inspects facilities. We found that MDH did a good job processing licensing applications, but it has not inspected facilities as frequently as required by law.

In addition, MDH has not always provided the Department of Human Services (DHS) with the data it needs to ensure its payments to assisted living facilities for Medical Assistance-funded services are appropriate. We recommend that MDH address its inspection backlog and provide more specific and accurate data to DHS. We also recommend that DHS improve the Assisted Living Report Card ratings it publishes online as a service to the public.

Our evaluation was conducted by David Kirchner (project manager), Eleanor Berry, and Hannah Geressu, with assistance from Mariyam Naadha and Kaitlyn Schmaltz. MDH and DHS staff cooperated fully with our evaluation, and we thank them for their assistance.

Sincerely,

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OLA

Summary **September 2026**

Assisted Living Facility Licensing

The Minnesota Department of Health (MDH) has performed some of its assisted living facility licensing responsibilities well, but it should make improvements related to inspections, transparency, and supporting the work of other agencies.

Report Summary

MDH Licensing Activities

MDH reviews applications and conducts on-site inspections to ensure that assisted living facilities comply with licensing requirements.

- MDH has generally ensured that applicants for assisted living facility licenses meet licensing requirements, but MDH has not inspected assisted living facilities as frequently as required by law. (pp. 16, 22–24)

  Recommendation ► MDH should comply with statutorily required timelines for as (p. 24)

- MDH has not established clear standards for imposing licensing sanctions—such as conditional or suspended licenses—on assisted living facilities. (pp. 28–29)

  Recommendation ► MDH should establish standards for imposing licensing sanctions. (pp. 29–30)

Quality of Care and Transparency

Both MDH and the Department of Human Services (DHS) provide information to the public about assisted living facilities.

- DHS publishes "assisted living report cards" that rate individual assisted living facilities. The report card ratings rely on limited information and do not compare facilities on key health or staffing measures. The report card ratings also do not incorporate information from maltreatment investigations. (pp. 33–37)

  Recommendation ► DHS should improve its assisted living report card methodology; if necessary, it should request additional data-gathering authority from the Legislature. (pp. 37–38)

- Facilities self-report the services they can provide on disclosure forms; MDH does not ensure that the information provided on these forms is accurate. (pp. 40–41)

Background

Assisted living facilities are a hybrid between health care facilities and residential housing. All assisted living facilities share some common characteristics, such as on-call or on-site nursing staff and food, laundry, and housekeeping services for residents. However, facilities vary widely in the number of residents they serve and the types of services they offer.

Broadly speaking, two assisted living models exist in Minnesota. In the residential home model, assisted living facilities serve a few residents in houses built as single-family homes. In the apartment model, facilities serve dozens of residents in apartment-style buildings built specifically to be care facilities. Facilities with five or fewer residents make up about half of all facilities but only about 9 percent of Minnesota's total assisted living capacity. They are heavily concentrated in the Twin Cities metropolitan area.

Assisted living facility licensing first went into effect on August 1, 2021. MDH is responsible for licensing assisted living facilities and ensuring facilities comply with statutory requirements.

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Recommendation ► MDH should improve the accuracy and usefulness of the information on the disclosure forms that assisted living facilities complete. (pp. 41–42)

- MDH posts inspection reports for individual facilities online but does not provide key summary information for consumers and the public. (pp. 42–43)

  Recommendation ► MDH should provide online summary information about its inspection findings. (p. 43)

Fragmented Oversight

MDH oversees assisted living *facilities*, while the Board of Executives for Long Term Services and Supports (BELTSS) oversees facility *directors* and DHS oversees Medical Assistance *payments* to facilities.

- MDH does not have sufficient authority to enforce the statutory requirement that assisted living facilities employ licensed assisted living directors. (p. 47)

  Recommendation ► The Legislature should consider giving MDH additional authority to monitor compliance with the statutory requirement that facilities employ a licensed assisted living director. (p. 48)

- MDH has not enforced the legal requirement that individuals serving as the director for more than one facility simultaneously must receive BELTSS approval. (pp. 48–49)

  Recommendation ► MDH should ensure that assisted living facilities that share a licensed assisted living director have BELTSS approval for the sharing arrangement. (p. 49)

- MDH has not provided DHS with clear information about the license status or capacity of some assisted living facilities, making it challenging for DHS to verify it is paying eligible providers. (pp. 50–52)

  Recommendations ► MDH should record clear start and end dates for assisted living facility licenses. MDH should create recordkeeping processes that accurately indicate an assisted living facility's current and historical resident capacity. (pp. 51, 53)

- DHS processes for verifying Medical Assistance payments for assisted living services may not catch certain types of misbilling. (pp. 53–54)

  Recommendation ► MDH and DHS should work together and with the Legislature to authorize MDH inspectors to assist in verifying whether assisted living facilities are providing state-funded services. (pp. 54–55)

Summary of Department Responses

In a letter dated September 1, 2026, MDH Deputy Commissioner Wendy Underwood wrote that "MDH greatly values and appreciates [OLA's] feedback" and that MDH "will use this opportunity to continue to ensure our quality assurance and quality control processes are well-designed, consistent, and effective." Deputy Commissioner Underwood described actions MDH has taken or will take to address OLA's recommendations, including coordination with other agencies and potential legislative proposals.

In a letter dated September 1, 2026, DHS Temporary Commissioner John Connolly wrote that DHS "agrees with the three recommendations that involve actions the department can take to improve assisted living services."

The full evaluation report, *Assisted Living Facility Licensing*,
is available at 651-296-4708 or: **www.auditor.leg.state.mn.us/assisted-living.htm**

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Introduction

Assisted living facilities offer long-term personal care for individuals who live in a common residential setting, such as a residential home or an apartment complex. Minnesota began licensing assisted living facilities in August 2021. Before that, assisted living facilities registered with the Minnesota Department of Health (MDH) as "housing with services" establishments and were subject to minimal requirements.

In August 2025, the Legislative Audit Commission directed the Office of the Legislative Auditor to examine how well MDH has implemented assisted living facility licensing. Our evaluation addressed the following questions:

- **How well has MDH complied with legislative requirements regarding licensing?**

- **To what extent does MDH's licensing process for assisted living facilities contribute to transparency, accountability, and quality of care?**

- **How effectively does MDH collaborate with other agencies that regulate assisted living facilities?**

To address these questions, we examined relevant state laws and regulations. We also reviewed the academic and policy literature on assisted living, and we conducted numerous interviews with MDH staff.

To better understand the nature of assisted living facilities and MDH's licensing work, we shadowed MDH inspectors during four assisted living facility inspections.[1] We conducted site visits at 10 assisted living facilities around the state. These site visits included interviews with both facility staff and residents and did not occur during MDH inspections. We also conducted a survey of all licensed assisted living directors in the state who served as the director of at least one facility.

To assess how well MDH staff implemented statutory licensing requirements, we obtained direct access to MDH's licensing document repository and selected a sample of 75 approved assisted living facility license applications. We reviewed the MDH files associated with those applications.

In addition, we requested and analyzed data on assisted living facilities from MDH, data on assisted living directors from the Board of Executives for Long Term Services and Supports (BELTSS), and data on individuals receiving financial assistance to cover assisted living costs from the Department of Human Services (DHS).

[1] State law and MDH use the term "survey" to refer to a routine inspection visit. We use the term "inspection" to distinguish it from our survey of assisted living directors and the surveys used by DHS to create the Assisted Living Report Card (see Chapter 3).

We also interviewed numerous stakeholders, including representatives of assisted living providers, advocates for people with disabilities, advocates for elderly adults, academic researchers, and staff from BELTSS, DHS, county social service agencies, the Office of Ombudsman for Long Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities.

We mostly focused our work on MDH's responsibilities. However, we also evaluated two functions DHS performs that relate to assisted living facility licensing. DHS produces the Assisted Living Report Card, which provides information to consumers on the quality of assisted living facilities across the state. We reviewed elements of the report card and analyzed some of its underlying data. In addition, we analyzed data on DHS payments to assisted living facilities for services provided to individuals receiving Medical Assistance. This analysis led us to some evaluative conclusions about how DHS uses MDH data. However, our review of DHS activities was very limited and was not intended to provide a comprehensive evaluation of DHS's responsibilities related to assisted living.

Although we reviewed a number of inspection and investigation reports, we did not look extensively at MDH's process for gathering and investigating maltreatment reports and other complaints.[2] We did not evaluate MDH's 2021 conversion of registered housing with services establishments to licensed assisted living facilities because this process is unlikely to occur again and does not reflect MDH's current licensing activities. We also did not examine the process by which licensed assisted living facilities can apply to relocate to a different site. That process was newly implemented in 2025, and only a few facilities had applied at the time we conducted our evaluation.

[2] Office of the Legislative Auditor, Program Evaluation Division, *Office of Health Facility Complaints* (2018) addressed this process comprehensively.

Chapter 1: Background

Thousands of Minnesotans rely on assisted living facilities to provide them with daily services and supports in a shared living environment. Assisted living facilities house and care for individuals who can manage some of their own care needs but require assistance with others.[1] The extent of care provided in assisted living facilities varies widely from resident to resident and from facility to facility.

In this chapter, we begin with an overview of how assisted living is defined in state law, followed by details on assisted living facilities that operate in Minnesota. We then provide a brief introduction to the licensing process and describe key licensing functions that the Minnesota Department of Health (MDH) performs. Finally, we discuss the role of other state agencies in assisted living facility licensing.

Overview

In the United States, assisted living facilities are regulated by state governments. Each state defines assisted living through its own statutes and administrative rules. As a result, the term "assisted living facility" has different meanings across the country.

Minnesota statutes define an assisted living facility as "a facility that provides sleeping accommodations and assisted living services to one or more adults."[2] Additional statutory provisions outline a broad set of characteristics that apply to Minnesota assisted living facilities, which we summarize in Exhibit 1.1.

As indicated by the list in Exhibit 1.1, assisted living facilities are a hybrid between health care facilities and residential housing. They operate as health care facilities in that residents must be assessed for medical needs by a registered nurse on a regular basis.[3] A facility staff person must be on site, awake, and available at all times, and a registered nurse must be on site or on call at all times.[4] Assisted living facilities may provide a wide variety of care services, including management and administration of medication; various treatments and therapies; and assistance with bathing, toileting, and other personal needs. Facilities are required to maintain individual records of treatments and services.[5]

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[1] Some assisted living facilities have "independent living" residents who do not have any care needs and who have essentially the status of a tenant. For example, a couple may share a unit in an assisted living facility, but one member of the couple needs services and the other does not.

[2] *Minnesota Statutes* 2025, 144G.08, subd. 7.

[3] *Minnesota Statutes* 2025, 144G.70, subd. 2. Nursing assessment requirements do not apply to residents who do not receive any assisted living services.

[4] *Minnesota Statutes* 2025, 144G.41, subd. 1(12) and (13).

[5] *Minnesota Statutes* 2025, 144G.43.

Exhibit 1.1

Characteristics of Assisted Living Facilities in Minnesota

Autonomy	• Participation by residents in planning for care and services • Ability of residents to refuse care or services if they wish • Freedom of residents to come and go as they wish, and to receive visitors • Facility support of resident councils and family councils
Food Service	• Three meals a day and access to food at any time • Food prepared to meet specialized diet*
Housing	• Private unit that can be locked • If sharing a unit, right to choose a roommate
Medical Care	• Individual service plan based on a nursing assessment updated at least every 90 days • Provision of or assistance with medication management and administration, treatments, therapies, and exercises* • Nurse oversight of all health care activities • Registered nurse on site or on call at all times • Ongoing infection control program
Mobility	• Hands-on assistance with transfers and movement within the facility* • Assistance arranging transportation to external appointments and activities
Personal Services	• Daily (or more frequent) checks on residents' health and safety* • Assistance with toileting, bathing, and personal grooming* • Housekeeping and laundry services • Social and recreational activities
Records	• Individual resident records, including documentation of services provided and medications administered
Staffing	• Staff on site who are awake and available at all times • Sufficient staffing to meet residents' scheduled and reasonably foreseeable unscheduled needs
Transparency	• Contracts with residents detailing services and charges • Facility notification to residents of services provided and residents' rights • Facility notification to residents of how to make complaints to external entities like ombudsman offices or MDH

Notes: Facilities are required by law to make available all elements listed except services marked with an asterisk. Asterisked services are listed in law as services that assisted living facilities may provide, but are not required to provide. The listing is illustrative, not comprehensive.

Source: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2025, 144G.

However, assisted living facilities also operate as a form of housing. Residents may live at facilities indefinitely and must be provided private units they can lock.[6] They sign a contract akin to a lease agreement with the assisted living facility for housing and the services they receive.[7] Residents have autonomy to choose whether to receive meals, participate in group activities, or access other services and amenities.[8] Residents may also choose not to receive care or services, although the facility has a responsibility to inform residents of the possible consequences.[9] Assisted living facilities must follow state landlord-tenant laws.[10]

Although assisted living facilities share common characteristics, the experience of assisted living residents can vary widely. For example, one resident may only require minimal services, such as occasional assistance with dressing and grooming, whereas another resident may require more medically complex services, such as wound care or blood glucose monitoring for diabetes.

Assisted Living with Dementia Care

An assisted living facility that advertises specialized care for individuals with dementia, or that has a secured dementia care unit, must obtain a special assisted living facility license. An "assisted living facility with dementia care" must meet extra requirements, such as ensuring management personnel and staff have dementia-specific training, complying with additional building specifications, and taking precautions to prevent residents from leaving the facility on their own.

The services available to residents can also vary across different facilities. Within the constraints of the law, facilities may choose to offer some services and not others. Some facilities provide limited services; others offer a much wider range. State law requires facilities to disclose to prospective residents what services they do and do not provide.[11]

Assisted Living Facilities in Minnesota

As of July 1, 2025, 2,279 assisted living facilities were in operation across the state, with facilities operating in 83 of Minnesota's 87 counties. Just over 600 of these facilities (27 percent) were licensed to provide dementia care. In the following sections, we provide information on the state's assisted living facilities, paying particular attention to facility size. The 2026 Legislature has directed MDH to work together with stakeholders to develop a new assisted living facility licensing category for facilities with a capacity of five residents or fewer.[12]

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[6] *Minnesota Statutes* 2025, 144G.41, subd. 1(10); and 144G.91, subd. 13(b). Residents may have a roommate.

[7] *Minnesota Statutes* 2025, 144G.50.

[8] *Minnesota Statutes* 2025, 144G.91.

[9] *Minnesota Statutes* 2025, 144G.91, subd. 5.

[10] *Minnesota Statutes* 2025, 144G.11.

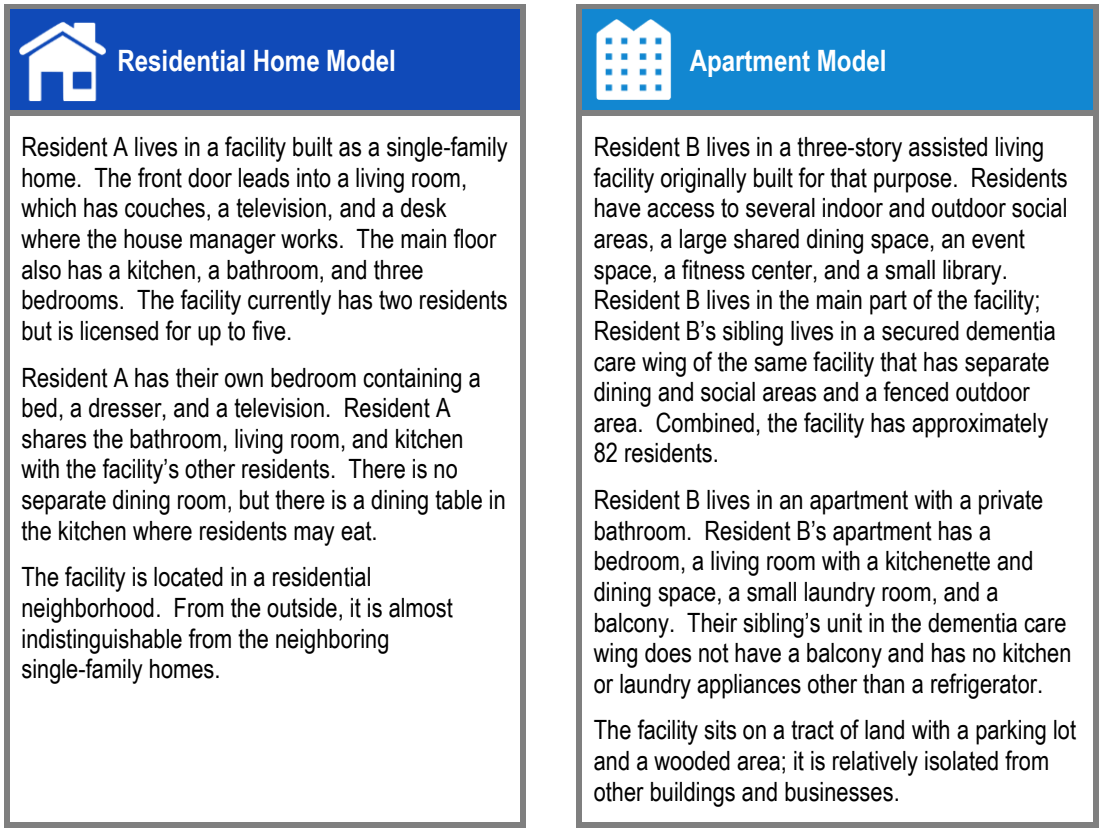
[11] *Minnesota Statutes* 2025, 144G.40, subd. 2(a).

[12] *Laws of Minnesota* 2026, chapter 121, art. 2, sec. 8.

Housing Models

The vast majority of assisted living facilities in Minnesota fit one of two models: a residential home model or an apartment model. In the residential home model, residents have private bedrooms but share the rest of the facility, including bathrooms. Buildings were originally built as single-family homes and usually house five or fewer residents. In the apartment model, residents live in apartment-style units with individual bathrooms that usually have a kitchenette or food preparation area. Buildings were originally built to be care facilities and often house 20 or more residents. We describe examples of these two models in Exhibit 1.2.[13]

Exhibit 1.2
Examples of Minnesota's Assisted Living Models



Source: Office of the Legislative Auditor.

MDH does not record the type of living arrangement each facility uses. However, we concluded the vast majority of assisted living facilities housing 5 or fewer residents—and many housing 6 to 10—fit the residential home model. We based our conclusion on conversations with MDH and industry associations and analysis of data about facility square footage. Not every facility perfectly fits one model or the other.

[13] The examples are based on specific facilities we visited during our evaluation.

MDH staff told us that residential home facilities appear to be somewhat more likely to focus their services on specific populations, such as individuals with similar care needs, individuals with shared ethnic or community backgrounds, or individuals who do not thrive in larger community settings. However, individuals from all types of backgrounds reside in all types of facilities.

Facility Capacity and Location

Assisted living facilities range widely in the number of residents they serve, from as few as 1 or 2 residents to more than 300.[14] MDH licenses each assisted living facility to serve up to a certain number of residents (the facility's capacity).[15] Very small facilities of five or fewer residents make up about one-half of the state's assisted facilities, as shown in Exhibit 1.3.[16] However, due to their small size, those facilities represent just 9 percent of the state's total resident capacity. Most of the state's assisted living resident capacity is in large facilities licensed to serve more than 50 residents.

Exhibit 1.3

One-half of Minnesota's assisted living facilities house five or fewer residents.

Facility Capacity	Number of Facilities	Percentage of Facilities	Percentage of Resident Capacity
1 to 5	1,178	52%	9%
6 to 10	209	9	2
11 to 20	137	6	3
21 to 50	332	15	18
51 to 100	259	11	30
101 or more	164	7	38
	2,279	100%	100%

Source: Office of the Legislative Auditor, analysis of MDH licensing data as of July 1, 2025.

The number of facilities operating changes constantly as facilities open and close—especially very small facilities. From January 2022 through June 2025, about four new assisted living facilities opened each week, on average. As shown in Exhibit 1.4, of the 753 new facilities that opened from January 2022 through June 2025, 678 (90 percent) were licensed to serve five or fewer residents.[17] Nearly one-half of facilities with five or fewer residents operating in July 2025 had opened within the preceding three and a half years.

Multiple stakeholders told us providers increasingly sought assisted living facility licenses for facilities fitting the residential home model after the Legislature instituted a moratorium on some other forms of licensure for small residential home care settings in 2009.[18] The moratorium includes community residential settings and adult foster care settings where the license holder does not reside.[19]

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[14] State law establishes a minimum capacity of one resident per assisted living facility; there is no maximum capacity. *Minnesota Statutes* 2025, 144G.08, subd. 7.

[15] The fee for obtaining a license is based on the capacity; larger facilities pay higher fees.

[16] Due to data limitations, numbers in all tables in this report that refer to facility capacity may not be exact.

[17] Although 753 new facilities opened during that time period, not all of those facilities remained open as of July 1, 2025.

[18] *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 8, codified as amended in *Minnesota Statutes* 2025, 245A.03, subd. 7.

[19] County social service agencies administer licenses for these settings with oversight from the Department of Human Services (DHS).

Exhibit 1.4

Many facilities with five or fewer residents opened and closed between January 2022 and July 2025.

Facility Capacity	Count on January 1, 2022	Opened January 2022 Through June 2025	Closed January 2022 Through June 2025	Count on July 1, 2025	Percentage Change
1 to 5	**862**	**678**	**395**	**1,178**	**+37%**
6 to 10	289	12	56	209	−28%
11 to 20	151	5	20	137	−9%
21 to 50	322	43	23	332	+3%
51 to 100	263	6	6	259	−2%
101 or more	139	9	0	164	+18%
	2,026	753	500	2,279	+12%

Notes: Only the total row sums as follows: first count + number opened − number closed = second count. The other rows do not sum in the same way because some facilities shifted between size categories (for example, changed their facility capacity from six residents to four residents).

Source: Office of the Legislative Auditor, analysis of MDH licensing data.

Very small facilities have also closed much more frequently than larger facilities. Of the 500 assisted living facilities that closed from January 2022 through June 2025, 395 (79 percent) served five or fewer residents. According to information that closing facilities provided to MDH, small facilities were most likely to close due to a lack of residents or switching to a different license type.[20] Facilities with a resident capacity of more than 10 residents, however, most commonly indicated they closed for other reasons, such as staffing issues.

As shown in Exhibit 1.5, the vast majority of small assisted living facilities are in the Twin Cities seven-county metropolitan area.[21] Ninety-seven percent of facilities serving five or fewer residents were located in the metropolitan area; 59 percent were located in Hennepin County. In comparison, more than half of the facilities with capacities of 11 or more residents were located outside of the metropolitan area.

Exhibit 1.5

Most small facilities are located in the Twin Cities Metropolitan Area.

Facility Capacity	Percentage Located in the Seven-County Metropolitan Area
1 to 5	97%
6 to 10	78%
11 or more	40%

Source: Office of the Legislative Auditor, analysis of MDH licensing data as of July 1, 2025.

[20] In 2021, the Legislature created a temporary pathway that allowed certain assisted living facilities to switch to different (non-assisted living) DHS licenses. *Laws of Minnesota* 2021, First Special Session, chapter 7, art. 13, sec. 5, codified as *Minnesota Statutes* 2022, 245A.03, subd. 7(a)(5).

[21] The Twin Cities seven-county metropolitan area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.

Resident Age

Facilities vary widely in the characteristics of residents to whom they provide services. Some facilities serve populations primarily 65 years and older with care needs related to aging. Others serve mostly individuals younger than 55 with long-term physical or mental disabilities.

The data available to us indicate that most assisted living residents live in facilities where the majority of residents are 65 years of age and older. MDH does not collect data on residents, but we collected some information about resident ages in a survey we conducted of assisted living directors.[22] Respondents to our survey who directed facilities with more than 20 residents reported that on average, the percentage of residents 65 years of age and older at their facilities exceeded 90 percent.

However, facilities with fewer residents were more likely to serve mostly younger residents than other facilities. As shown in Exhibit 1.6, over one-third of facilities serving five or fewer residents whose directors answered our survey served mostly individuals under age 55. Conversely, directors reported that only 20 percent of those facilities had a majority of residents 65 years of age and older.

Exhibit 1.6

Survey responses indicate that many small facilities serve mostly adults under 55 years of age.

Number of Residents	Number of Facilities Where Most Residents are Under 55	Total Number of Facilities	Percentage
1 to 5	232	674	34%
6 to 10	12	118	10%
11 to 20	8	120	7%
21 to 50	6	179	3%
51 to 100	1	134	1%
101 or more	0	57	0%
	259	1,282	20%

Notes: Numbers are based on responses of 877 assisted living directors; some respondents directed more than one facility.

Source: Office of the Legislative Auditor, survey of assisted living directors, 2025.

[22] We surveyed all licensed assisted living directors serving as the director of at least one Minnesota facility. We received survey responses from 989 of the 1,498 directors we contacted, for a response rate of 66 percent. Some respondents served as directors for more than one facility.

Staff

Assisted living facilities generally employ a combination of unlicensed and licensed staff. Many day-to-day services can be provided by unlicensed staff. However, certain assisted living services must be provided by a licensed health care professional. For example, a registered nurse must reassess the health care needs of each resident at least once every 90 days.[23] Nurses must also oversee the provision of health care services by unlicensed staff.[24]

Our survey of assisted living directors indicated facilities varied in their resident-to-staff ratios.[25] Due to their small size, facilities with five or fewer residents typically had the fewest residents per on-site staff person. Survey respondents reported that over 85 percent of such facilities they directed had ratios of two or fewer residents per staff person at noon on Wednesdays. Larger facilities had, on average, a higher number of residents per staff person, as is shown in Exhibit 1.7.

Exhibit 1.7

Survey responses indicated that, on average, large facilities had a higher number of residents per staff person than small facilities at noon on Wednesdays.

Number of Residents	Average Number of Residents per Staff Person
1 to 5	1.5
6 to 10	2.9
11 to 20	4.5
21 to 50	6.3
51 to 100	8.6
101 or more	14.0

Note: Numbers are based on responses of 861 assisted living directors; some respondents directed more than one facility.

Source: Office of the Legislative Auditor, survey of assisted living directors, 2025.

Assisted living directors answering our survey reported that most facilities they directed—including all facilities with more than 50 residents—would have at least one licensed health care professional on duty at noon on Wednesdays. A minority of facilities (28 percent) with five or fewer residents represented in our survey responses would not ordinarily have a licensed health care professional on duty at noon on Wednesdays.

In the overnight hours, resident-to-staff ratios were often much higher, especially at facilities with more than 20 residents. Directors answering our survey for more than 90 such facilities reported ratios of at least 30 residents per on-site staff person at midnight on Wednesdays; some reported ratios of 60 or more residents per staff person. Many facilities of all sizes reported they did not have a licensed health care professional on site overnight.[26]

[23] *Minnesota Statutes* 2025, 144G.70, subds. 2 and 4.

[24] *Minnesota Statutes* 2025, 144G.41, subd. 1(4); and 144G.62.

[25] We chose two times—noon and midnight on Wednesdays—and asked directors answering the survey how many staff typically were on duty at each time.

[26] As we described in the Overview section of this chapter, facilities must have a nurse on call, but not necessarily on site, at all times. *Minnesota Statutes* 2025, 144G.41, subd. 1(13).

Payment Sources

Many assisted living facility residents pay for some of their assisted living costs through Medical Assistance, Minnesota's Medicaid program, administered by the Department of Human Services (DHS). Medical Assistance pays for many assisted living services (called "customized living" services) through the Medicaid Home- and Community-Based Services (HCBS) waiver program. Under the program, certain residents eligible to receive Medical Assistance for nursing home services are allowed to live in less restrictive settings than nursing homes, if they choose to do so.[27]

In one month (June 2024), at least 1,800 assisted living facilities received Medical Assistance payments under the HCBS waiver program. As we show in Exhibit 1.8, these payments supported services for more than 15,000 residents and totaled more than $100 million. In Fiscal Year 2024, HCBS wavier program payments to assisted living facilities totaled approximately $1.1 billion.

Exhibit 1.8

In June 2024, large shares of residents at small facilities used Medical Assistance to pay for assisted living services.

Facility Capacity	Total Capacity of All Facilities	Medical Assistance Recipients	Total Medical Assistance Paid (In Millions)	Average Medical Assistance Paid Per Recipient
1 to 5	4,932	2,838	$ 36.6	$12,897
6 to 10	1,634	899	9.6	10,651
11 to 20	2,317	885	5.0	5,596
21 to 50	10,807	3,878	18.6	4,801
51 to 100	19,272	4,386	19.6	4,458
101 or more	23,643	2,921	12.0	4,111
	62,605	15,807	$101.3	$ 6,409

Note: Due to data limitations, numbers of recipients and facility capacities may not be exact. Approximately 80 individuals are represented twice in the table because they were at more than one facility during the month.

Source: Office of the Legislative Auditor, analysis of MDH and DHS data.

Data on Medical Assistance payments suggest that small, residential home model facilities are heavily reliant on Medical Assistance funding. Across all facilities with five or fewer residents, residents using Medical Assistance to pay for assisted living costs made up more than one-half of the total capacity of all facilities.

Responses to our survey suggested that the proportion of residents in small facilities being funded by Medical Assistance is even higher than the numbers in Exhibit 1.8 would indicate because many facilities are not full to capacity. Survey respondents said that in 90 percent of the facilities with five or fewer residents they directed, *every* resident used Medical Assistance funding to cover some of their assisted living costs.

[27] Nearly all Medical Assistance payments to assisted living facilities are for customized living services through HCBS. Less than 1 percent of Medical Assistance payments to assisted living facilities in Fiscal Year 2024 were for other services.

Licensing

Before August 2021, MDH *registered*—rather than *licensed*—assisted living facilities as "housing with services" establishments.[28] The housing with services classification applied to a variety of care settings that provided a combination of housing and support services to residents. This lack of licensure limited the state's ability to regulate assisted living facilities. State law did not authorize MDH or any other state agency to evaluate whether housing with services establishments met registration requirements. In addition, some housing with services establishments were not required to register if less than 80 percent of their residents were age 55 or older.[29]

After action by the 2019 Legislature, MDH began licensing assisted living facilities on August 1, 2021. MDH uses two key processes to ensure that facilities comply with statutory licensing requirements. We discuss these processes in greater detail in Chapter 2:

- **Written applications.** Applicants complete an application and provide supporting documentation to show that they have met the requirements to obtain or renew a license. MDH staff perform a desk review of the application materials, ask for additional information if necessary, and independently verify key information. Licensed facilities submit renewal applications each year; facilities must submit additional applications to change ownership or relocate.

- **In-person inspections and investigations.** Trained MDH staff visit each facility with a few hours' advance notice and assess how well the facility is meeting its statutory obligations. Unlike the application review, MDH staff do not rely solely on documentation, and can see for themselves whether the facility is meeting requirements for medication administration, food service, fire safety, and other responsibilities. Routine inspections occur every two years, though new facilities and those that have changed owners are inspected sooner.[30] On-site investigations into complaints can occur at any time.

Failure to pass regulatory standards in either process can lead to negative consequences. Failure to submit complete or correct applications generally leads to a delay in licensure, because MDH will require the applicant to revise its application or add necessary supporting documentation before it will approve the application. Failure to pass inspection standards may lead to correction orders and fines.[31] When inspections or

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[28] Some housing with services establishments provided health care services to their residents by also holding a home care license. Alternatively, individuals living in housing with services establishments could receive health care services from a licensed third party.

[29] Office of the Legislative Auditor, Program Evaluation Division, *Office of Health Facility Complaints* (2018) raised serious concerns about the state's limited oversight of housing with services establishments.

[30] State law and MDH use the term "survey" to refer to a routine inspection visit. We use the term "inspection" to distinguish it from our survey of assisted living directors and the surveys used by DHS to create the Assisted Living Report Card (see Chapter 3).

[31] As of 2026, fines fund an MDH-administered competitive grant program that awards grants to assisted living facilities and other entities to improve outcomes and quality of care for assisted living residents.

investigations reveal serious problems, MDH may require a facility to meet certain conditions to continue operating (by issuing a "conditional license") or force the facility to cease operations by suspending, revoking, or refusing to renew its license.

MDH's Health Regulation Division

MDH's Health Regulation Division oversees assisted living facility licensing in Minnesota. The division is responsible for carrying out the licensing functions we described in the previous section; it also provides guidance on assisted living laws and requirements to facilities and the public. In addition to assisted living facilities, the Health Regulation Division regulates many other types of facilities, including nursing homes, hospitals, birth centers, hospices, body art establishments, funeral homes, and others.

As of July 2026, the Health Regulation Division had 105 full-time staff whose responsibilities included assisted living facility licensing and regulation. These staff included program managers, licensing inspectors, complaint investigators, administrative support personnel, and data analysts.

Health Regulation Division Responsibilities

- Accepts, processes, and approves license applications
- Inspects facilities
- Monitors compliance with licensing laws and rules
- Investigates complaints and allegations of license violations
- Issues correction orders and levies fines
- Issues licensing sanctions, such as license suspensions or revocations
- Provides public information about licensing laws and activities

MDH funds its licensing activities through a combination of state appropriations, special revenue from licensing fees, and other designated funds. The department's total funding for the Health Regulation Division in Fiscal Year 2025 was $61.4 million; of this amount, $41 million came from state funding appropriated from general and special revenue funds through the legislative budget process. The remainder of the division's funding came from federal sources.

The Health Regulation Division spent at least $13.9 million in Fiscal Year 2025 specifically on assisted living facility licensing activities. However, the total amount MDH spent regulating assisted living was likely higher because some division staff perform work across multiple licensure categories.

Other Oversight Entities

MDH coordinates with other state entities in overseeing assisted living facilities, including the DHS and the state licensing boards that license assisted living directors and nurses employed by assisted living facilities.[32] We briefly discuss these entities below; we discuss the roles of DHS and the Board of Executives for Long-Term Services and Supports (BELTSS) in greater detail in Chapter 4.

Department of Human Services

DHS makes payments to assisted living facilities for the care they provide to residents through the HCBS waiver program. DHS manages the eligibility assessments and service standards for Medical Assistance-funded services delivered in assisted living settings, which it calls "customized living." These assessments and standards, which are based on federal and state requirements, operate somewhat independently from MDH's licensing procedures for assisted living facilities. For example, Medical Assistance policies set limits on the age of individuals served under specific HCBS waivers in certain facilities; those age limitations are unrelated to MDH licensing requirements.

DHS also produces the Assisted Living Report Card, a quality measurement tool intended to provide consumers with comparable information about assisted living facilities. The report card is based on inspection results and surveys of assisted living residents and their family members. Facilities are rated on a scale of one to five stars in each of five categories: resident quality of life, family satisfaction, resident health, safety, and staffing.

Professional Licensing Boards

State law requires each assisted living facility to employ specific licensed staff: an assisted living director and a clinical nurse supervisor.[33] Professional licensing boards regulate the qualifications and licensure of these roles.

BELTSS is responsible for licensing assisted living directors. BELTSS establishes licensure requirements for assisted living directors, including education, experience, and examination standards. BELTSS investigates complaints against assisted living directors and may impose disciplinary actions if necessary.

Each assisted living facility must employ a clinical nurse supervisor who is licensed as a registered nurse by the Minnesota Board of Nursing. The board establishes standards for nursing licensure and practice, including requirements for education, examination, and professional conduct.

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[32] Other state agencies also have oversight responsibilities because most assisted living facilities are businesses that must follow requirements applicable to all businesses. For example, they must register with the Office of the Secretary of State, file tax returns with the Department of Revenue, and report payroll information to the Department of Employment and Economic Development.

[33] *Minnesota Statutes* 2025, 144G.10, subd. 1a; and 144G.41, subd. 4.

Chapter 2: MDH Licensing Activities

The introduction of assisted living licensing sought, in part, to improve the accountability of assisted living providers by creating a set of common standards and expectations. As we discussed in Chapter 1, the Minnesota Department of Health (MDH) monitors compliance of assisted living facilities with those standards and expectations through two key processes: the license application process and the inspection process.

Key Findings in This Chapter

- MDH has generally ensured that applicants for assisted living facility licenses meet licensing requirements.
- Assisted living directors generally reported positive experiences with MDH's application process.
- MDH has not inspected assisted living facilities as frequently as required by law.
- Statutes give MDH significant discretion to determine when to impose licensing sanctions on assisted living facilities, but MDH has not established clear standards for doing so.

In this chapter, we discuss MDH's performance in carrying out these two processes. We begin by describing key requirements for license applications and the process by which MDH reviews applications and issues licenses. We then discuss the extent to which MDH has used inspections to hold facilities accountable to licensing requirements. Lastly, we examine MDH's use of licensing sanctions when facilities do not demonstrate compliance with licensing requirements.

License Applications

Statutes require each assisted living facility to have its own license.[1] If the same individual or entity operates more than one assisted living facility, they must apply for and obtain a separate license for each facility.

As shown in Exhibit 2.1, MDH processes four types of license applications. A facility's first license application leads to a *provisional license*, which is valid for only one year and cannot be renewed.[2] During the provisional license period, a facility must successfully undergo an MDH inspection to receive a *full license,* which is also valid for one year but can be renewed.[3]

A license applicant must submit a completed application form and required supplemental documentation to MDH in order to obtain an assisted living facility license. Applications include information about the applicant (usually a business); the facility's owners, managers, and administrators; the physical building; the services and amenities to be provided; and insurance coverage.

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[1] *Minnesota Statutes* 2025, 144G.10, subd. 1. An assisted living facility may consist of more than one building on the same property or adjacent properties.

[2] *Minnesota Statutes* 2025, 144G.16, subds. 1–2.

[3] *Minnesota Statutes* 2025, 144G.17.

Exhibit 2.1
Types of License Applications

Type of Application	Description
Provisional	For applicants opening a new facility; leads to a provisional license
Change of Ownership	For existing facilities changing owners; leads to a full license
Relocation	For existing facilities that move to a new location; existing license maintained at the new location
Renewal	For all other existing facilities; leads to a full license

Note: A provisional license lasts for one year; facilities must pass an inspection during the provisional license period to obtain a full license.

Source: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2025, 144G.16, 144G.17, 144G.19, and 144G.195.

MDH rarely denies license applications outright. When a license application is incomplete or incorrect, MDH staff notify the applicant and allow them to submit additional information to make the application complete. In some cases, MDH staff and an applicant may communicate for several months as the applicant continues to revise their application.

Application Reviews

We reviewed a sample of 75 approved license applications to evaluate the extent to which MDH collected information required by law.[4] We focused primarily on MDH's review of information about the license applicant, the assisted living services and amenities provided at the facility, and the facility's owners and management personnel.

MDH has generally ensured that applicants for assisted living facility licenses meet licensing requirements.

Most of the license applications we reviewed met all of the licensing requirements we checked, as shown in Exhibit 2.2. In some cases, a single piece of information appeared to be missing or incomplete in an application. Several applications we reviewed contained correspondence indicating that MDH staff had reviewed the application; identified missing, incomplete, or inconsistent information; and requested further information from the license applicant.

Exhibit 2.2
Licensing requirements were mostly met in a sample of 75 applications.

Licensing Requirement	Compliance Rate
License Application	100%
Engineering plans/specifications (Provisional Application only)	100%
Listing of owners and ownership percentages	97%
Transfer document (Change of Ownership Application only)	96%
Evidence of providing care (Renewal Application only)	95%
Uniform Disclosure of Assisted Living Services and Amenities	91%

Source: Office of the Legislative Auditor.

[4] We randomly selected 25 provisional license applications, 25 change of ownership applications, and 25 renewal applications that MDH approved between August 2021 and April 2025. We did not include relocation applications in our sample, as MDH had processed very few relocation applications at the time of our review.

Independent Verification

MDH staff independently check some of the information provided in each license application; for example, they confirm that the applicant's business is registered with the Office of the Secretary of State, that the assisted living director and clinical nurse supervisor have appropriate licenses from their respective licensing boards, and that the facility has completed background studies on owners and managerial staff that have direct contact with residents. MDH policies instruct licensing staff to retain documents showing they have completed these independent verifications.[5]

Due to incomplete documentation, it is unclear whether MDH independently verified licensing information as required by its policies.

In more than one-quarter of the license applications we reviewed, MDH licensing staff did not follow MDH policies requiring them to retain documentation showing that they verified information provided by applicants, as shown in Exhibit 2.3. As a result, we could not confirm that MDH licensing staff had followed the department's verification procedures.

When we asked MDH administrators about the missing documentation, they provided documentation showing that the information could be currently verified. However, MDH could not demonstrate that the information had been verified at the time staff reviewed and approved the applications.

MDH administrators told us they believed that department staff performed the required verification checks during application review. However, they acknowledged that staff did not always follow MDH policy to retain documentation showing that the verification checks occurred.

Exhibit 2.3

MDH staff did not always document that they had independently verified information submitted by applicants.

Information to be Verified	Files Containing Verification Documentation
Office of the Secretary of State Registration (Provisional License and Change of Ownership Application only)	88%
Background studies for all direct owners and individuals providing direct contact	73%
License credentials for Assisted Living Director	72%
License credentials for Clinical Nurse Supervisor	71%

Note: Some requirements applied to only some applications; percentages include only relevant applications.

Source: Office of the Legislative Auditor, analysis of assisted living facility license applications.

[5] MDH's process for checking the licensure status of assisted living directors may not capture limitations placed on that status by the Board of Executives for Long Term Services and Supports (BELTSS). We describe that concern in Chapter 4 as part of a discussion of the overlapping roles of MDH and BELTSS.

RECOMMENDATION

MDH should ensure it retains documentation used to verify information provided by license applicants.

MDH's policy to independently verify key information in application documents is a sound one. Verification helps ensure that individuals who oversee facilities and care for residents are properly qualified and that the licensee has met legal requirements. There are multiple ways MDH could ensure that its licensing staff are conducting verifications as its policies require. The approach it has taken, requiring staff to download and retain documentation to show that verification occurred, is reasonable.

However, a good policy is only effective if it is implemented consistently. In response to questions we raised, MDH administrators told us they have updated the department's training and coaching of licensing staff to ensure they follow correct procedures for retaining documentation.

Opinions on the Application Process

To learn more about MDH's licensing of assisted living facilities, we surveyed assisted living directors in Minnesota that were associated with at least one assisted living facility.[6]

Assisted living directors generally reported positive experiences with MDH's application process.

Respondents to our survey with experience preparing license applications expressed mostly positive opinions about MDH's communication with applicants, its adherence to state law, and its timeliness. As shown in Exhibit 2.4, 72 percent of assisted living directors expressing an opinion agreed or strongly agreed that MDH staff were responsive to questions about completing renewal applications, and 68 percent agreed or strongly agreed that MDH staff were responsive to questions about provisional license applications.

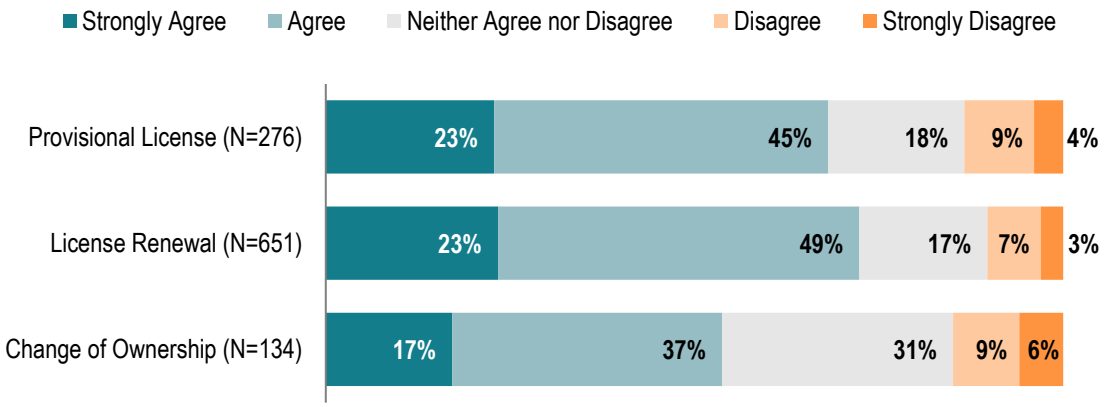
Although more than half of assisted living directors expressing an opinion about each application type agreed that MDH processed applications in a reasonable length of time, a significant minority of respondents disagreed. As also shown in Exhibit 2.4, over 20 percent of those expressing an opinion disagreed or strongly disagreed that MDH processed provisional license and change of ownership applications in a reasonable length of time.[7]

[6] Some directors serve as the director for multiple facilities. We did not send surveys to individuals holding assisted living director licenses who did not direct any facility. We received survey responses from 989 of the 1,498 directors we contacted, for a response rate of 66 percent. We excluded "Don't Know" responses from our survey results; for each question about licensing requirements or MDH's licensing process, fewer than 4 percent of assisted living directors selected "Don't Know."

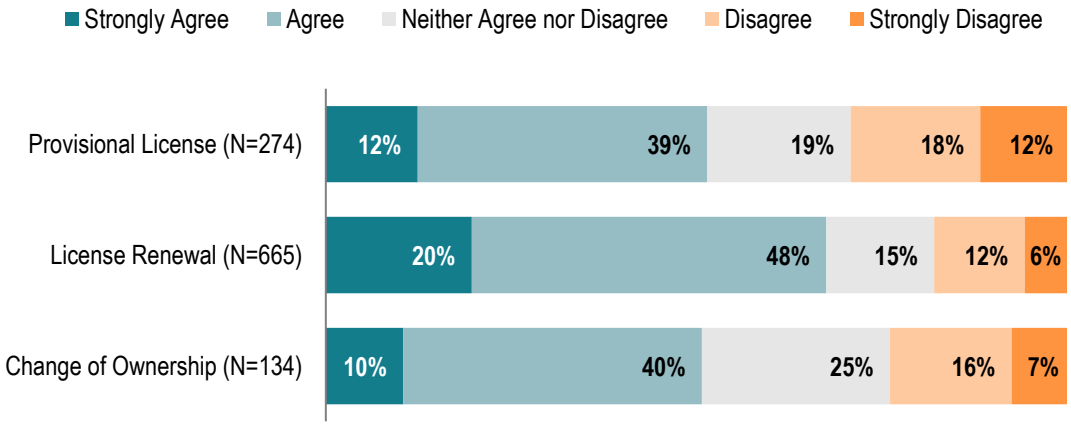
[7] We were not able to independently measure MDH's processing times for license applications. MDH's data did not contain sufficient information to determine the length of time between the date on which MDH received all required application documentation and the date on which MDH approved the application.

Exhibit 2.4

Assisted living directors responding to our survey generally agreed that MDH staff were responsive to questions about completing license applications.



Assisted living directors also generally agreed that MDH processed applications in a reasonable length of time.



Notes: Respondents only answered questions about application types they said they had prepared or helped to prepare. "Don't Know" responses and nonresponses are excluded. Percentages may not sum to 100 due to rounding.

Source: Office of the Legislative Auditor, survey of licensed assisted living directors, fall 2025.

Inspections

MDH's second key licensing responsibility is to inspect assisted living facilities.[8] Inspections enable MDH staff to go on site to determine whether assisted living facilities are complying with state licensing requirements. State licensing requirements set basic standards for the quality of care facilities must provide; inspections are the primary way MDH evaluates whether the assisted living facilities it licenses are meeting those standards.

MDH is also responsible for investigating complaints concerning assisted living facilities. Complaints that MDH investigates include allegations of maltreatment and allegations of noncompliance with specific licensing requirements. These investigations focus on specific allegations rather than on compliance with a broader set of licensing requirements.

Common Violations Cited in Inspections

- State Food Code violations, such as food stored at an incorrect temperature
- State Fire Code violations, such as missing or incorrectly placed smoke alarms
- Violations related to fire safety and evacuation plans, such as incomplete plans or lack of evidence the facility has completed evacuation drills
- Violations related to disaster planning and emergency preparedness, such as an incomplete emergency preparedness plan

During an inspection, three MDH staff—a nurse, an engineer, and a sanitarian—review the facility's compliance with different licensing requirements.[9] Among other tasks, the nurse tours the facility; observes medication storage and administration; conducts interviews with staff and residents; and reviews facility policies, procedures, and training plans. The engineer conducts a facility walk-through and reviews facility documents related to fire safety, such as records of fire drills and smoke alarm testing. A sanitarian inspects the facility's kitchen and reviews requirements related to food safety. The MDH nurse is typically on site for two to five days, depending on the size of the facility and extent of findings, while the engineer and sanitarian typically spend less than one day at the facility.

By law, MDH may not give facilities advance notice of an inspection prior to the day it occurs but may contact the facility on the day of the inspection to ensure that someone is available on site.[10] MDH staff told us that inspectors typically give facilities one to two hours' notice on the day of the inspection.

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[8] State law and MDH use the term "survey" to refer to a routine inspection visit. We use the term "inspection" to distinguish it from our survey of assisted living directors and the surveys used by DHS to create the Assisted Living Report Card (see Chapter 3).

[9] An environmental health specialist/sanitarian is an individual registered with MDH who is qualified to "plan, organize, manage, implement, and evaluate one or more program areas comprising the field of environmental health," including "food, beverage, and lodging sanitation." *Minnesota Rules*, 4695.2600, subp. 8.

[10] *Minnesota Statutes* 2025, 144G.30, subd. 3.

If an inspector finds that a facility is not in compliance with a statutory requirement, MDH cites the facility for the violation. As part of the citation, MDH issues a correction order that requires the facility to correct the violation and specifies the time frame in which it must do so. Violations may also result in fines or other licensing actions. MDH may conduct one or more follow-up inspections to determine whether the facility has corrected violations.[11]

MDH assigns a scope and severity level to individual violations. Scope depends on the number of residents or staff involved and the pervasiveness of the problem. Severity levels describe the impact to resident health or safety. At the time we conducted our research, severity levels ranged from one to four, with four as the most severe.[12] For example, MDH inspectors would likely classify a violation that results in harm to a resident, such as a medication error that impacts a resident's health, as a higher severity level infraction than a documentation error.

Examples of Violations at Each Severity Level, Fiscal Year 2025

Level 1: Resident contracts were missing required language about a resident's right to designate a representative.

Level 2: An employee did not follow handwashing and glove use guidelines when administering medication.

Level 3: The facility did not have a background study on file for one of its current employees.

Level 4: Facility staff did not respond appropriately when a resident experienced a medical emergency.

It has been rare for facilities to receive a spotless inspection. In Fiscal Year 2025, MDH completed 1,122 inspections. MDH issued correction orders for 96 percent of those inspections, issuing over 11,000 total correction orders and assessing over $1.1 million in fines.[13] For most inspections for which MDH issued correction orders, the highest level of severity of the correction orders was Level 2 out of four, with Level 4 as the most severe.

Timeliness

MDH must inspect facilities within time frames specified in law.[14] These time frames vary based on the most recent type of license application that MDH has approved, as shown in Exhibit 2.5.

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[11] Statutes require MDH to conduct a follow-up investigation for certain violations, depending on their severity. *Minnesota Statutes* 2025, 144G.30, subd. 7.

[12] Starting in Fiscal Year 2026, MDH began issuing correction orders on a scale of one to five at the direction of the Legislature. Statutes establish fine amounts for individual violations based on severity levels, as follows: (l) Level 1: no fines, (2) Level 2: $500, (3) Level 3: $1,000, (4) Level 4: $3,000, and (5) Level 5: $5,000. *Laws of Minnesota* 2025, First Special Session, chapter 3, art. 1, sec. 73, codified as *Minnesota Statutes* 2025, 144G.31, subds. 2 and 4.

[13] These totals do not reflect all correction orders and fines MDH issued to assisted living facilities in Fiscal Year 2025; MDH also issued additional correction orders and fines through its complaint investigation process.

[14] This section focuses on the comprehensive inspections required by law every two years. On-site investigations in response to maltreatment reports and other complaints go through a different scheduling process.

Exhibit 2.5
Inspection Time Frames

Most Recent Application	Time Frame in which MDH Must Complete Inspection
Provisional License	Within one year of licensure, but after facility begins providing services
Renewal	Within two years of previous inspection
Change of Ownership	Within six months of change of ownership approval
Relocation	No new inspection required; same time frame as license renewal

Note: Inspection time frames can be extended under certain circumstances.

Source: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2025, 144G.16, 144G.19, 144G.195, and 144G.30.

Although the law requires that MDH conduct inspections within a specified time frame, MDH has flexibility to schedule inspections early. For instance, if MDH has a large number of inspections that it must complete by the same date, it can spread them out over several months so that it does not have to complete them all at once.

MDH has not inspected assisted living facilities as frequently as required by law.

MDH did not meet statutory deadlines for the inspections it had to conduct within the first two years of the implementation of assisted living licensing.[15] When assisted living licensing began in August 2021, almost 2,000 facilities previously registered as housing with services establishments converted to assisted living facilities.[16] MDH licensed nearly all of these facilities in August 2021, which meant that MDH then had to inspect these facilities by August 2023, two years after licensing began. In addition, MDH had one year to inspect any facilities that applied for new (provisional) licenses.

MDH inspectors did not complete their first round of inspections for converting facilities until October 2024, more than one year after they were required. MDH administrators told us that many more facilities sought assisted living licensure than MDH had expected, creating a large cohort of assisted living facilities that all had similar inspection deadlines.

[15] Due to limitations with MDH data, we did not evaluate whether MDH conducted inspections within six months following each change in ownership.

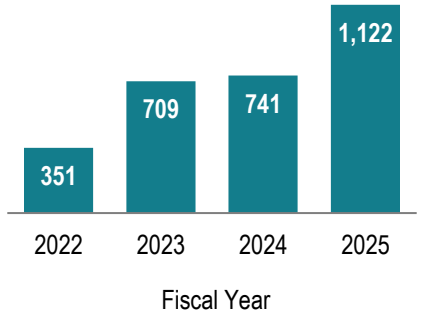
[16] Facilities that converted from housing with services registrations did not go through the provisional licensing process. Thus, the first inspections for these facilities were due two years, rather than one year, after they converted to assisted living facilities.

Since 2021, MDH increased the total number of inspections it completed each year, as shown in Exhibit 2.6, but continued to have difficulty meeting inspection deadlines. Although its timeliness appeared to be improving, it still completed a significant number of inspections late that were due in 2025.

As Exhibit 2.7 shows, for inspections due from January through June 2025, MDH completed 29 percent on time and completed another 30 percent within 90 days of the inspection due date. Although less than half of these inspections were on time, MDH had significantly reduced the number of its inspections occurring more than 90 days late compared to the two previous six-month periods.

Exhibit 2.6

The number of assisted living facility inspections MDH completed each year increased.

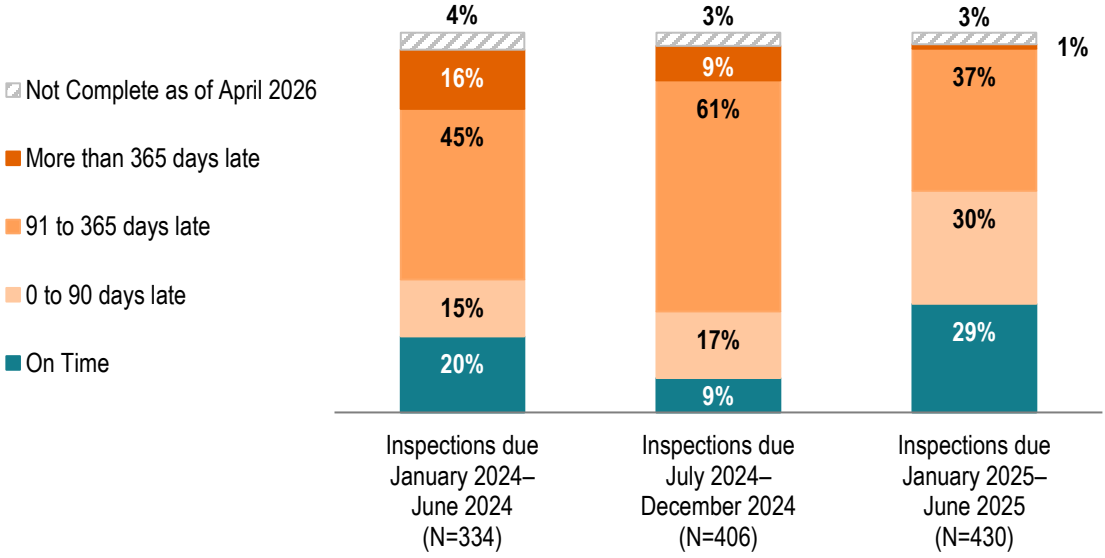


Note: Counts for FY 2022 include inspections completed from August 2021 through June 2022.

Source: Office of the Legislative Auditor, analysis of MDH inspections data.

Exhibit 2.7

MDH's timeliness in completing inspections improved, but the department continued to have difficulty meeting statutory requirements.



Note: Some of the facilities with still-incomplete inspections closed before MDH could inspect them, so they are no longer outstanding. Percentages may not sum to 100 due to rounding.

Source: Office of the Legislative Auditor, analysis of MDH inspections data.

Timely inspections help MDH ensure that facilities are meeting assisted living requirements, including those meant to promote resident health, safety, and well-being. For a facility with a provisional license, the licensing inspection is typically the first time MDH staff observe how the licensee provides services to residents. As we describe later in this chapter, MDH has denied full licenses to nearly 60 provisionally licensed facilities as a result of inspection or investigation findings, demonstrating the importance of timely inspections. Failing to meet inspection deadlines could potentially leave vulnerable adults living in conditions that are a risk to their health and safety.

As we discussed in Chapter 1, new (provisional) assisted living facilities open frequently in Minnesota. An MDH administrator told us this constant introduction of new facilities makes it challenging to improve timeliness. Provisional facilities must be inspected within one year of opening. MDH staff told us that they are working on efficiencies to further increase the number of inspections staff can complete each year. However, with the growing number of assisted living facilities MDH needs to inspect, the department may need more resources to meet inspection deadlines.

RECOMMENDATION

MDH should comply with statutorily required timelines for assisted living facility inspections.

When assisted living facility licensing began in 2021, MDH was surprised by and unprepared for the number of facilities it had to inspect. Five years later, MDH's inspection caseload is more predictable, and it has increased the number of inspections it performs each year—but it is still behind schedule. If MDH does not have sufficient resources to manage its inspection caseload, it should request additional resources from the Legislature.

Opinions on Inspections

In our survey of assisted living directors, we asked directors about their experiences with MDH's inspections, including correction orders their facilities received. We also spoke with some facility owners, assisted living directors, facility staff, and provider organization staff about inspections.

Assisted living directors who responded to our survey generally expressed positive opinions about several aspects of MDH inspections.

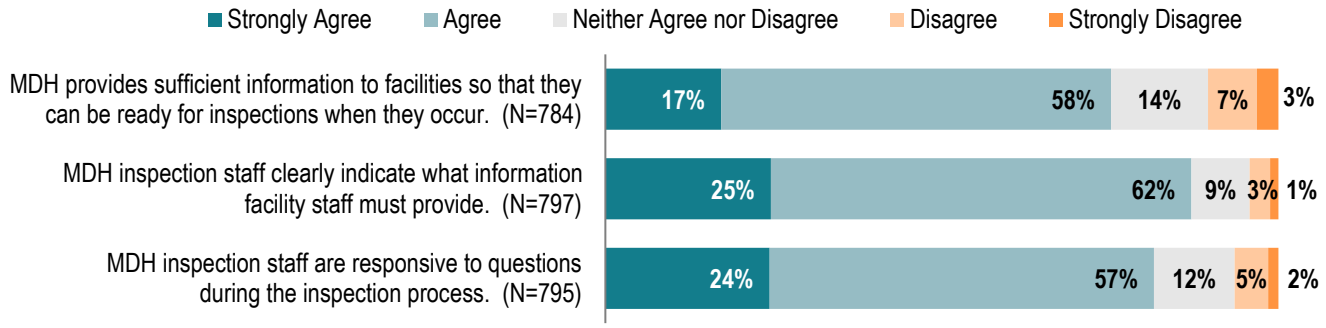
Survey respondents who had participated in one or more inspections were mostly satisfied with MDH's communication before and during inspections, as shown in Exhibit 2.8.

Survey respondents who had participated in one or more inspections also generally reported that MDH's inspection standards were consistent with state law and that inspections promoted resident health and safety and provider accountability. For example, 86 percent (683) of those expressing an opinion agreed or strongly agreed that MDH's inspections protect the health and safety of assisted living residents.

Of survey respondents that had recently received a correction order for a facility they direct, respondents generally expressed positive opinions about the process of receiving and resolving correction orders, as shown in Exhibit 2.9. Over 80 percent of directors expressing an opinion in response to each question agreed or strongly agreed that MDH provided clear information about why their facilities received correction orders, that MDH clearly informed facilities what they must do to respond to correction orders, and that resolving correction orders reduced risks or improved conditions for facility residents. A lower percentage of those expressing an opinion—but still a clear majority—agreed or strongly agreed that correction orders accurately reflected the conditions found by MDH staff.

Exhibit 2.8

Assisted living directors who responded to our survey generally expressed positive opinions about MDH's communication before and during inspections.

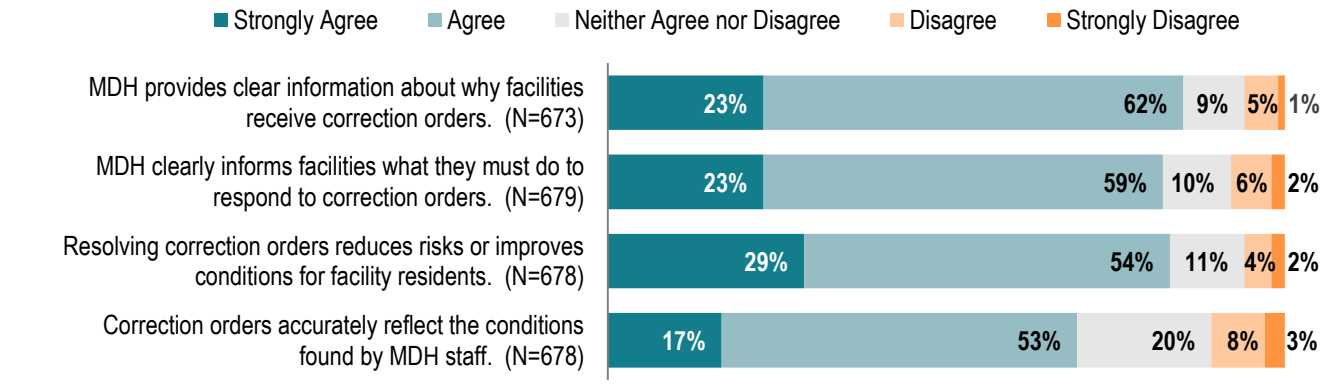


Notes: Respondents were only asked questions about inspections if they reported that they had participated in an inspection. "Don't Know" responses and nonresponses are excluded.

Source: Office of the Legislative Auditor, survey of licensed assisted living directors, fall 2025.

Exhibit 2.9

Assisted living directors who responded to our survey generally expressed positive opinions about MDH's correction order process.



Notes: Respondents were only asked questions about correction orders if they reported that MDH had issued a correction order to a facility they directed between October 2023 and the date they responded to the survey in fall 2025. "Don't Know" responses and nonresponses are excluded. Percentages may not sum to 100 due to rounding.

Source: Office of the Legislative Auditor, survey of licensed assisted living directors, fall 2025.

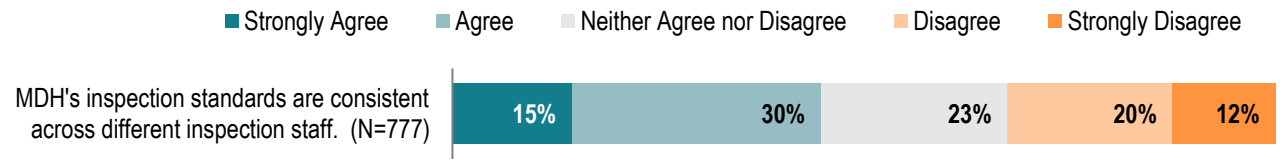
Although assisted living directors who responded to our survey generally expressed positive opinions about different aspects of MDH inspections, some facility owners, directors, and stakeholders reported that MDH's inspection teams enforce regulations inconsistently. Some of these stakeholders told us in survey responses or interviews that they had experienced or were aware of instances in which different inspectors made conflicting decisions. A few assisted living directors or owners said that they made changes in response to inspections but were later cited again for the same issue. For example, one director reported that they made changes to a facility policy in response to one inspection, but the next inspector cited the facility for that policy and wanted the facility to change the policy back to the original.

In our survey of assisted living directors, we asked directors who had experienced one or more inspections to what extent MDH's inspection standards were consistent across different inspection staff. Assisted living directors had mixed responses, as shown in Exhibit 2.10. Of the 777 directors expressing an opinion in response to the question, one-third (33 percent) disagreed or strongly disagreed that MDH's inspection standards were consistent across different inspection staff. Less than one-half of directors (45 percent) agreed or strongly agreed that MDH's inspection standards were consistent.

> My facility was cited and fined for an issue that I know other buildings were not held accountable for, despite having similar conditions. This inconsistency in enforcement undermines the fairness and credibility of the regulatory process.
>
> **— Assisted Living Director**

Exhibit 2.10

Assisted living directors had mixed responses when asked if MDH's inspection standards are consistent across different inspection staff.



Note: "Don't Know" responses and nonresponses are excluded.

Source: Office of the Legislative Auditor, survey of licensed assisted living directors, fall 2025.

MDH Health Regulation Division administrators acknowledged that maintaining consistency across inspections has been challenging. They cited the large number of requirements inspectors need to check, the need to familiarize new inspectors with inspection procedures, the growing number of facilities, and the different types of assisted living facilities as challenges for maintaining consistency. Administrators said they have pursued several strategies to improve consistency across inspection staff. For example, the division has instituted a quality management process in which a quality management staff person spot-checks correction orders to determine whether they adhere to the law and MDH guidance.

Licensing Sanctions

MDH has several options available to penalize facilities that are not in compliance with assisted living regulations. For less serious compliance issues, MDH may resolve its concerns with corrective orders and fines. However, when facilities have egregious violations or do not correct problems found in past inspections, MDH has the authority to take action that affects a facility's license to operate. MDH can suspend or revoke a license, deny a full license to a provisionally licensed facility, refuse to renew a license, or issue a conditional license.[17]

MDH has rarely revoked, suspended, or refused to renew assisted living facility licenses. From the beginning of assisted living licensing in August 2021 through June 2025, MDH revoked the license of only one facility and suspended the licenses of three facilities, as shown in Exhibit 2.11. In addition, MDH initiated—but did not complete—the revocation process for three other facilities. Two of these facilities voluntarily closed, and the third was allowed to continue operating. Also during this period, MDH refused to renew one facility's license, but rescinded its decision after the facility agreed to a change in ownership.[18]

Exhibit 2.11

Licensing Sanctions, August 1, 2021, Through June 30, 2025

Licensing Sanction	Total Facilities
Conditional License: The facility continued to operate, but under conditions set by MDH.	189
License Denial: MDH denied a full license to a provisional facility.	59
Refusal to Renew: MDH refused to renew the license of a fully licensed facility.	0
Revocation: MDH terminated a facility's license in between renewals.	1
Suspension: MDH temporarily prohibited a facility from operating.	3

Notes: Counts include only facilities with licensing sanctions resulting from an inspection or investigation and reflect outcomes of hearings or reconsiderations. Due to MDH data limitations, counts may not be exact.

Source: Office of the Legislative Auditor, analysis of MDH licensing data.

License denials occur more commonly than revocations, suspensions, or refusals to renew. Between August 2021 and June 2025, MDH denied licenses for nearly 60 facilities. All of these denials occurred following a complaint investigation or initial inspection of a facility operating with a provisional license. If MDH denies a full license to a facility operating with a provisional license, the facility must close.

MDH issued conditional licenses for approximately 189 assisted living facilities from August 2021 through June 2025. A facility can continue to operate while the conditional license is in place, but it is at risk of losing its license if it does not fulfill the required conditions. Common conditions include prohibiting the facility from admitting new residents and requiring the facility to hire a consultant to help the facility comply with MDH requirements. (The facility selects its own consultant, but MDH must approve the choice. In most cases, the consultant must be a

[17] *Minnesota Statutes* 2025, 144G.16, subd. 3(b); and 144G.20, subd. 1.

[18] We provide information on licensing sanctions through the end of Fiscal Year 2025 to be consistent with other data in this report. However, MDH initiated another five revocations or suspensions in the first six months of Fiscal Year 2026.

registered nurse.) The consultant submits reports to MDH on the facility's progress. MDH issues most conditional licenses for 90 days, but conditional licenses may be shorter or last longer.

Statutes allow licensees to challenge MDH's licensing sanctions. Generally, licensees are entitled to a hearing in front of an administrative law judge if MDH decides to impose a licensing sanction.[19] However, if MDH decides to deny a full license or apply a conditional license to a provisionally licensed facility, the licensee may request a reconsideration, but it is not entitled to a hearing.[20]

Statutes give MDH significant discretion to determine when to impose licensing sanctions on assisted living facilities, but MDH has not established clear standards for doing so.

State laws that authorize MDH to impose licensing sanctions grant the department significant discretion to determine when sanctions are justified. For example, MDH must apply a conditional license or refuse to grant a full license to a provisionally licensed facility if MDH finds during the initial inspection that the facility is not "in substantial compliance" with assisted living requirements.[21] Based on statutes, a facility is not in substantial compliance when it does not comply with requirements sufficiently to prevent "unacceptable" risks to residents.[22] The definition of "unacceptable" is left to MDH.

Statutes outline other circumstances in which MDH *may* impose licensing sanctions. For example, according to statutes, MDH may impose a licensing sanction, such as a revocation or conditional license "if the owner, controlling individual, or staff of an assisted living facility" commits any of 15 actions, including violating any assisted living statutes or rules or performing "any act detrimental to the health, safety, and welfare of a resident."[23] Statutes allow, but do not require, MDH to impose an immediate licensing sanction in response to any violation cited in an inspection or complaint investigation if that violation is above the lowest severity level.[24]

Although state law requires MDH to revoke, suspend, or refuse to renew facility licenses in certain circumstances, those circumstances have rarely occurred. For example, statutes require MDH to revoke a facility's license "if a controlling individual of the facility is convicted of a felony or gross misdemeanor that relates to operation of the facility or directly affects resident safety or care."[25] MDH must also

[19] *Minnesota Statutes* 2025, 144G.20, subd. 13.

[20] *Minnesota Statutes* 2025, 144G.16, subd. 4.

[21] *Minnesota Statutes* 2025, 144G.16, subd. 3.

[22] *Minnesota Statutes* 2025, 144G.08, subd. 67.

[23] *Minnesota Statutes* 2025, 144G.20, subd. 1. "Controlling individual" includes individuals and entities with at least a 5 percent ownership interest in an assisted living facility. "Controlling individual" also includes other individuals and entities such as those with an ownership interest in the assisted living facility building or the land on which it is located. *Minnesota Statutes* 2025, 144G.08, subds. 15 and 48.

[24] *Minnesota Statutes* 2025, 144G.31, subd. 4.

[25] *Minnesota Statutes* 2025, 144G.20, subd. 4.

take action to revoke, suspend, or refuse renewal of a facility's license if a facility incurs multiple or repeated uncorrected violations within a two-year period that have "created an imminent risk to direct resident care or safety" or are in the "highest daily fine categories prescribed in rule."[26] An MDH administrator told us that MDH has never cited these statutory requirements as the basis for a license revocation. The administrator suggested that MDH would most likely use its discretionary authority to issue licensing sanctions long before a facility would reach the point that statutorily required sanctions would be triggered.

MDH has not developed its own standards for when it will use the discretion granted to it by the Legislature to issue licensing sanctions. Instead, senior Health Regulation Division staff told us that supervisory and management staff decide potential licensing sanctions on a case-by-case basis. From August 2021 through June 2025, MDH issued the maximum fine for the most serious violations to at least 19 facilities.[27] It took action to revoke the license for only one of those facilities; it did not revoke, suspend, or deny licenses to other facilities receiving maximum fines.

Senior Health Regulation Division staff told us that the division generally applies a licensing sanction because a facility has a serious violation that constitutes a threat to the safety of residents. They said that MDH does not want to use a "one size fits all" approach for applying sanctions when standards for applying sanctions are not established in statutes. They also said that MDH may consider imposing a licensing sanction (especially requiring a facility to retain a consultant) if a facility has a history of multiple, less serious citations that have remained uncorrected. They said that staff consider the history of MDH's concerns about the facility over time and whether the facility is improving or worsening in its compliance.

Senior Health Regulation Division staff told us that they focus on bringing facilities into compliance, rather than revoking or denying licenses. They said that staff weigh the potential harm caused by displacing residents when they are considering closing a facility.

RECOMMENDATION

MDH should establish standards for imposing licensing sanctions on assisted living facilities.

Without standards for implementing licensing sanctions, it is difficult for MDH to ensure consistency in how it applies licensing sanctions across licensees. Standards would help MDH have a clear course of action when a licensee's violations meet a certain threshold, helping MDH hold licensees accountable when warranted.

For licensees, clear standards outlining when MDH will implement licensing sanctions would provide greater transparency and fairness. Licensing sanctions are serious actions that affect the ability of licensees to operate their businesses. Even when the

[26] *Minnesota Statutes* 2025, 144G.20, subd. 11. MDH has not defined any daily fine categories in rule.

[27] During the time period of August 2021 through June 2025, the fine for the most serious compliance and maltreatment violations was $5,000.

sanction does not result in a facility closure, it can significantly affect the licensee. For example, facilities must bear the cost of hiring a consultant under a conditional license. It is reasonable for licensees to expect MDH to have predictable standards for when it will close a facility or place conditions on a license.

Establishing standards would not necessarily prevent MDH from exercising discretion in its decisions about licensing sanctions. MDH can still retain discretion to waive a sanction that would ordinarily be applied depending on circumstances. For example, during an inspection, MDH might cite a facility for violations that meet the threshold MDH has established for applying sanctions. If the facility takes immediate and effective action to correct the violations, MDH might waive the sanctions it would ordinarily apply (for example, requiring the facility to hire a consultant to help it get into compliance).

Chapter 3: Quality of Care and Transparency

An important function of the Minnesota Department of Health (MDH) is to provide information to consumers and the public about its licensing activities and assisted living facilities in general. Reliable information about quality of care, availability of services, and violations identified during facility inspections can help consumers make informed decisions about their care.

In this chapter, we discuss the challenges of measuring the quality of care provided in assisted living facilities and examine information about assisted living facilities published by the Department of Human Services (DHS). Then, we examine three different methods MDH has used to provide information about assisted living facilities to consumers and the public and the extent to which those methods have provided accurate and useful information.

Key Findings in This Chapter

- No national consensus exists on how to assess the quality of assisted living care.
- DHS's assisted living report card ratings do not incorporate information about allegations substantiated through MDH maltreatment investigations.
- Facilities self-report the services they provide on required disclosure forms; MDH does not ensure that the information provided on these forms is accurate.
- MDH posts inspection reports for individual facilities online but does not provide key summary information for consumers and the public.

Challenges to Assessing Quality of Care

As we discussed in Chapter 1, Minnesota has over 2,200 assisted living facilities. Faced with such a wide array of choices, it would be useful for consumers to have independent assessments of the quality of care each facility provides. However, national efforts to develop useful, comparable measurements of assisted living quality have not been very successful.

No national consensus exists on how to assess the quality of assisted living care.

"Assisted living" is not a well-defined term. It first emerged in the 1980s, as entrepreneurs began to develop living arrangements for seniors with needs between fully independent living and institutional nursing home care.[1] This model fell outside of existing regulatory frameworks, so assisted living care was often defined by businesses themselves. Assisted living could, and did, mean different things depending on the services businesses chose to offer.

[1] Keren Brown Wilson, "Historical Evolution of Assisted Living in the United States, 1979 to the Present," *The Gerontologist* 47, Special Issue III (2007): 8–22.

Eventually, states began regulating assisted living facilities, but in doing so, they developed different requirements for assisted living facilities and thus different definitions of assisted living care.[2] Authors of a 2021 journal article counted 182 licensure classifications combined in 350 distinct ways across the 50 states and the District of Columbia.[3]

The lack of consensus on what assisted living care actually entails has been an obstacle to creating any widely accepted national standards regarding the quality of care provided in assisted living facilities. In 2001, a Congressional committee formed a workgroup including 48 national organizations to make recommendations to Congress for promoting quality in assisted living care. However, the workgroup failed to reach consensus on a definition of assisted living, despite what one observer described as a "grueling" series of meetings.[4] Many of the report's recommendations were accompanied by dissenting opinions from workgroup participants.

In addition to definitional challenges, creating consistent, comparable measurements for quality of care may be complicated by the wide variety of resident care needs. For example, some assisted living residents may want to go outdoors whenever they would like, to enjoy the changing seasons and activities in their surrounding neighborhoods.[5] But for other assisted living residents with cognitive or memory limitations, easy access to the outdoors would be hazardous because they cannot independently manage environmental risks like traffic or severe weather. Thus, the same set of outdoor access policies may be viewed as too restrictive for some residents and too permissive for others. Similar tradeoffs exist for many assisted living services, such as medication management or personal grooming.

Authors of a 2025 review article (based on work funded by DHS) identified less than two dozen studies in the peer-reviewed academic literature since 2000 reporting data on measures of assisted living quality.[6] The authors suggested that the measures of quality proposed in the peer-reviewed and non-peer-reviewed studies they reviewed could be loosely grouped into nine different "domains," but there were no commonly accepted measures.[7] The authors concluded that the "lack of standardized measurement of

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[2] Catherine Hawes and Charles D. Phillips, "Defining Quality in Assisted Living: Comparing Apples, Oranges, and Broccoli," *The Gerontologist* 47, Special Issue III (2007): 40–50.

[3] Lindsey Smith, et al., "Connecting policy to licensed assisted living communities, introducing health services regulatory analysis," *Health Services Research*, 56, vol. 3 (2021): 540–549.

[4] Assisted Living Workgroup, *Assuring Quality in Assisted Living: Guidelines for Federal and State Policy, State Regulation, and Operations* (Report to the U.S. Senate Special Committee on Aging), American Association Homes and Services for the Aging, 2003, https://theceal.org/resources/assisted-living-workgroup-alw-report/, accessed July 24 2025, 11–15; and Wilson, "Historical Evolution of Assisted Living," 19.

[5] Minnesota's Assisted Living Bill of Rights gives each resident the right to enter and leave the facility as they choose, consistent with the resident's service plan. *Minnesota Statutes* 2025, 144G.91, subd. 9.

[6] Tetyana P. Shippee, et al., "Measurement of Quality in Assisted Living in the United States of America: A Scoping Review," *Journal of the American Medical Directors Association* 26 (2025): 105355, 3. The review was limited to studies of United States assisted living settings.

[7] The domains were: (1) core values and philosophy, (2) physical and social environment, (3) care services and integration, (4) service availability, (5) staffing, (6) resident quality of life, (7) resident and family satisfaction, (8) resident health outcomes, and (9) safety.

quality impedes provision of person-centered, value-based care in assisted living settings in the United States."[8]

Assisted Living Report Card

While no national standards for assisted living quality exist, Minnesota does produce a formal assessment of assisted living facilities' quality of care. This assessment is modeled on an existing assessment of nursing homes.

DHS, not MDH, reports to the public about quality of care at Minnesota assisted living facilities.

DHS has issued annual report cards for nursing homes since 2006. The report cards provide ratings for nursing homes on a scale of one to five across several categories, including resident satisfaction and staff retention. The ratings are based on information collected from surveys of residents and their families, MDH inspections, and federally required reporting by nursing homes of resident and staff characteristics.

In 2019, the Legislature directed DHS to develop resident and family surveys to be administered at assisted living facilities; the 2019 and 2021 Legislatures appropriated a total of $6.7 million for the development and administration of these surveys.[9] DHS used these surveys to develop assisted living report cards, and began posting them online in 2024. DHS posts report cards for all facilities for which it has data; if it has incomplete data, it posts an incomplete report card.

As shown in Exhibit 3.1, the assisted living report card that DHS developed uses two primary sources of information: (1) surveys of residents and their family members, and (2) MDH inspection reports. Working with researchers from the University of Minnesota, DHS developed a scoring system to turn the survey results into two ratings—resident quality of life and family satisfaction—and the inspection results into three ratings—resident health, safety, and staffing.

Exhibit 3.1
Assisted Living Report Card

Facilities receive a rating of one to five stars in each of five categories. Ratings are in comparison to other facilities in the same size category (small, medium, large) and in the same geographic category (metro or outstate).

Rating category	Source information
Resident Quality of Life	Surveys of assisted living residents
Family Satisfaction	Surveys of family members of assisted living residents
Resident Health	Health-related violations identified in routine MDH inspections
Safety	Safety-related violations identified in routine MDH inspections
Staffing	Staffing-related violations identified in routine MDH inspections

Note: Violations unrelated to health, safety, or staffing do not affect a facility's report card rating.

Source: Office of the Legislative Auditor, review of DHS documentation.

[8] Shippee, et al., "Measurement of Quality in Assisted Living," 7.

[9] *Laws of Minnesota* 2019, chapter 60, art. 5, sec. 1(e); and *Laws of Minnesota* 2021, First Special Session, chapter 7, art. 13, sec. 25; art. 16, sec. 2, subd. 6; and art. 16, sec. 18. The direction to DHS (but not the appropriation) is codified in *Minnesota Statutes* 2025, 256B.439, subd. 3d. The Legislature did not explicitly direct DHS to develop an assisted living report card using the surveys, but documentation related to the law's passage indicated that was the intended purpose.

The report card ratings are calculated by comparing facilities to others similar in location and size. For example, the report card assigns ratings to large facilities in the Twin Cities metropolitan area by comparing them to other large facilities in the metropolitan area.[10] Facilities only receive higher ratings if they score significantly better than average among their peers. Thus, one should not compare a large facility's rating to the ratings for medium- or small-sized facilities, because their ratings are based on different comparison groups.

The assisted living report card ratings rely on limited information and do not compare facilities on key health or staffing measures.

Other than the information gathered from resident and family surveys, DHS uses only publicly available information from MDH inspections to create the report cards. Both sources of information are useful, but the Legislature has not authorized or directed DHS or MDH to gather other information that could provide more comprehensive information that could be used to assess facilities' quality of care.

For example, a key function of assisted living facilities is to provide health care and other assistive services to residents. However, neither DHS nor MDH gathers information on the health of assisted living residents—they do not even track how many residents facilities serve or how frequently residents move in and out.[11] Thus, the ratings on the report card do not reflect health outcomes for residents unless MDH inspectors find a violation related to health outcomes. By contrast, DHS's nursing home report card contains ratings that are calculated based on the number of nursing home residents who experience continence issues, infections, accidents, hospitalizations, pressure sores, and moderate to severe pain.

The sufficiency and quality of staffing is a popular indicator of the quality of an assisted living facility. In the review article described at the beginning of this chapter, the authors noted that staffing "received the highest level of assigned importance" across the studies they reviewed, although there was no consensus on how to measure it.[12] As with health outcomes, neither DHS nor MDH gathers information about assisted living facility staffing levels or qualifications. Thus, assisted living report card ratings do not reflect staffing practices unless MDH inspectors find a violation related to staffing. By contrast, the nursing home report card includes ratings based on staff hours worked per resident at each nursing home, the frequency of staff turnover, and the use of temporary staff.

As long as a facility meets the minimum requirements in law, it cannot improve its report card ratings for resident health or staffing by improving its performance. For example, if a facility shifted from using on-call nurses to having a nurse on site at all times, that change would have no impact on the facility's report card ratings for resident health or staffing. Both staffing models meet the minimum requirements in law, and so both would have the same effect on the report card ratings.

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[10] For the purposes of the report card, DHS defines small, medium, and large facilities as having facility capacities of 1 to 5 residents, 6 to 25 residents, and more than 25 residents, respectively.

[11] MDH does collect a facility's current number of residents when it renews its license annually.

[12] Shippee, et al., "Measurement of Quality in Assisted Living," 7.

Statutes give DHS no authority to gather information directly from assisted living facilities to develop report card ratings; DHS is only authorized to survey assisted living residents and their families (and facilities must permit them to do so).[13] MDH may gather information directly from facilities, but it is unclear whether MDH can use that authority to collect information for the purpose of strengthening the report card. Statutes give MDH wide discretion to collect from facilities any "information sufficient to show that the applicant meets the requirements of licensure."[14] However, DHS's publication of assisted living report cards is not part of the licensure process.

Most report cards for assisted living facilities have incomplete ratings; approximately half of assisted living facilities will never have complete ratings under DHS's current report card model.

As of July 1, 2025, DHS's report card website had incomplete ratings for 93 percent of the 2,293 assisted living facilities listed. Seventy-five percent of the assisted living facilities had no ratings based on MDH inspection results (resident health, safety, and staffing), and 60 percent had no ratings based on resident or family surveys (resident quality of life and family satisfaction).

DHS staff told us that they expect the inspection-based data to become more populated as more inspections occur. The report cards included data on inspections conducted since July 2024.

However, ratings for resident quality of life and family satisfaction will likely continue to be largely incomplete due to the small size of many assisted living facilities. Responses to DHS's resident and family surveys are confidential. DHS does not publish ratings based on survey results when too few surveys are completed for a given facility, leaving the report card partially incomplete. DHS has suspended surveying residents at facilities with a capacity of less than seven residents because it likely would not be able to report any results due to confidentiality concerns.

As we discussed in Chapter 1, approximately half of the state's assisted living facilities have a capacity of five or fewer residents. The report cards for these facilities will thus never be complete under the current model.

DHS's assisted living report card ratings do not incorporate information about allegations substantiated through MDH maltreatment investigations.

As we explained in Chapter 2, MDH staff conduct two types of on-site visits to check facilities' compliance with state law. Routine inspections occur at least once every two

[13] *Minnesota Statutes* 2025, 256B.439, subd. 3d. By contrast, DHS has statutory authority to collect statistical and cost information from every nursing home providing care to individuals using Medical Assistance. *Minnesota Statutes* 2025, 256R.09. DHS may also gather cost data from assisted living facilities enrolled as Medical Assistance providers for the purpose of calculating reimbursement rates. *Minnesota Statutes* 2025, 256S.21, subd. 3.

[14] *Minnesota Statutes* 2025, 144G.12, subd. 1. The law states that MDH can collect unspecified "statistical information" and "any other information" that MDH requires.

years and are a complete review of facility compliance with all aspects of assisted living laws. MDH staff may also conduct on-site investigations of maltreatment reports and other complaints at any time; these visits focus only on compliance related to the specific allegations.[15]

Although both routine inspections and complaint investigations can result in violation findings and correction orders, DHS has used only information from routine inspections in creating the report card ratings. Because the report card does not incorporate violations found during complaint investigations, important information about a facility's performance may not be reflected.

For example, one assisted living facility with multiple substantiated maltreatment allegations over the previous 18 months—including five separate incidents that led to one resident death and four hospitalizations—received average ratings on its assisted living report card for resident health, safety, and staffing. The maltreatment findings all resulted from complaint investigations, not the facility's regular inspection, and thus were not incorporated into the facility's ratings.

A DHS administrator told us that the department's report card developers originally intended the report card to incorporate investigation findings, but said that the different format of investigation findings and inspection findings created challenges. Further, DHS determined that MDH's data did not distinguish between cases where an individual staff member was found responsible for maltreatment and cases where the facility was found responsible. Drawing on input from a stakeholder group the department had assembled to advise it on report card implementation, DHS decided that report card information should only incorporate those cases where the facility was found responsible. A DHS administrator told us that if MDH becomes able to provide more detailed investigation data, it would report investigation outcomes as part of the report card. DHS did add hyperlinks to MDH investigation reports to its online report card in May 2026.

DHS's assisted living report cards do not indicate when MDH has taken action to suspend or revoke a facility's license.

In Exhibit 3.2, we show the assisted living report card ratings for resident health, safety, and staffing for six assisted living facilities whose licenses were suspended or revoked by MDH as a result of inspections or maltreatment investigations. None of these report cards indicated that MDH had taken action to close the facilities due to unacceptable risks to facility residents. In several instances, the ratings are average or above average.

[15] MDH refers to all concerns it investigates as "complaints." The great majority of complaints are allegations of maltreatment, but a complaint could involve any violation of law. For example, MDH could initiate an investigation into a report of exposed wiring, although no maltreatment was alleged.

Exhibit 3.2

DHS Assisted Living Report Card Ratings for Facilities with Suspended or Revoked Licenses, 2025–2026

Facility	Resident Health	Safety	Staffing
Brainerd Carefree Living	★★★★	★★★	★★★★
Bright Path Homes	★★★	★★	★
Caring Hearts Home Care Inc.	★★★★	★★	★★★★
Golden Nest LLC	★	★★	★
Miles Vents Inc.	★★★	★★★★	★★★
Rise Home Health Care LLC	★★	★★	★

Notes: All ratings were posted after MDH had issued the licensing sanctions. Three other facilities with suspended or revoked licenses had no ratings. Some facilities appealed MDH's sanctions.

Source: Office of the Legislative Auditor, analysis of MDH and DHS records.

Not all of these facilities closed as a result of the suspensions or revocations (some successfully appealed or reached other agreements with MDH to remain open). Nonetheless, MDH license sanctions are important information that relates to a facility's ability to provide quality care.

RECOMMENDATION

DHS should improve its assisted living report card methodology; if necessary, it should request additional data-gathering authority from the Legislature.

Report cards can provide important and helpful information to consumers and the public. However, the information DHS uses to construct the report cards is not sufficient for a full picture of the services that facilities provide or the care that residents receive. Further, the report cards' omission of information about substantiated maltreatment allegations and licensing sanctions can produce incomplete and misleading ratings.

Both consumer satisfaction surveys and inspection results are useful for providing some information about the quality of care at assisted living facilities. But that information is insufficient. DHS cannot incorporate many straightforward statistics like staffing ratios into its report cards; it has no data on either numbers of staff or numbers of residents. MDH also does not collect these data. If neither DHS nor MDH believe they have the legal authority to request key information from assisted living facilities to improve report card ratings, they should seek such authority from the Legislature.[16]

However, DHS does not use other important information that is already available to it. Under all circumstances, DHS report cards should reflect when a facility's license has been suspended or revoked. DHS should also modify its report cards to report instances

[16] We do not take a position on whether it would be better for MDH to collect data from assisted living facilities and then provide the data to DHS for use in the report cards, or for DHS to collect data directly.

where MDH has issued a conditional license for a facility.[17] Additionally, DHS should incorporate information from complaint investigations into its report card ratings. Failing to include serious maltreatment findings as part of the report card methodology can lead to inappropriately high ratings for facilities that have been found responsible for maltreating residents.

Further, we are not persuaded that it would be inappropriate to lower a facility's report card ratings because maltreatment committed at the facility was the fault of an individual. We believe that report card ratings could incorporate any instance when MDH investigators substantiate that maltreatment occurred—regardless of whether the facility or a staff member was found to be at fault. Alternatively, DHS could work with MDH to obtain more nuanced data about maltreatment findings.

If the number of residents in a facility is very small, it is challenging for DHS to protect residents' confidential survey responses when providing summary information from resident surveys. However, DHS could combine survey results from multiple facilities with the same owner to provide aggregated report card ratings for groups of facilities with shared ownership. Although such information would be less precise than information drawn from an individual facility, DHS could note when a report card combines survey results from multiple facilities.[18]

DHS administrators told us that they were open to providing report card ratings at the ownership level, but had been stymied by the complexity of determining whether facilities share ownership. However, as of July 1, 2025, at least 45 percent of assisted living facilities with a capacity of less than seven residents shared a federal tax identification number with at least one other facility. Although combining facility ratings using federal tax identification numbers would not address every situation involving shared or overlapping ownership, doing so would significantly reduce the number of facilities with incomplete report cards.

Transparency

As part of its licensing activities, MDH makes certain information about Minnesota's assisted living facilities available to the public. The information ranges from simple directory information about where facilities are located to detailed information about violations of state law found during inspections or investigations.

In this section, we discuss three sources of information provided by MDH that increase transparency for assisted living residents and their families: (1) basic directory information, (2) information on assisted living facility services, and (3) inspection reports.

[17] As we discussed in Chapter 2, a conditional license is a serious licensing sanction under which a facility is allowed to remain open only by agreeing to abide by certain conditions set by MDH.

[18] DHS could also decline to publish aggregated ratings if survey responses differ so significantly among facilities within an ownership group that an aggregated rating would provide misleading information.

Online Directory

MDH maintains an online directory of health care providers. It includes not only assisted living facilities, but also other providers that MDH licenses, such as birth care centers, body art establishments, hospices, hospitals, speech-language pathologists, and outpatient surgery centers.

The directory contains limited information. At the time we began our evaluation, its entries on assisted living facilities consisted only of the name of the facility, address and contact information, the license type, licensing date, and the facility capacity.

Information that MDH provided in its online directory of assisted living facilities was sometimes inaccurate and did not indicate when facilities were under licensing sanctions.

Our initial review of the directory showed that MDH had not removed some facilities from the directory that had stopped operating. In a few instances, facilities were listed in the directory despite having had no valid license and no MDH permission to operate for more than a year.[19]

Further, the online directory provided no information regarding whether listed facilities were facing licensing sanctions. As we described in Chapter 2, MDH has the authority to place conditions on a license to ensure that the facility corrects deficiencies identified as the result of an inspection or investigation. In more egregious cases, the department may also suspend or revoke a facility's license. Other than revocations (which led to removal from the directory), MDH licensing sanctions were not noted in the online directory.

The information displayed in MDH's online directory provided potentially inaccurate or incomplete information not only to members of the public, but also to other state agencies. Staff at both DHS and the Board of Executives for Long Term Services and Supports (BELTSS) told us that they routinely checked MDH's online directory to determine whether assisted living facilities were currently licensed and made use of this information in conducting their own regulatory activities.

Administrators in MDH's Health Regulation Division acted promptly to address the inaccuracies in the online provider directory after we raised concerns in September 2025. Within two weeks, MDH reconfigured the directory so that facility listings included by default the facility's most recent license start and end dates.[20] Even though some no-longer-licensed facilities continued to appear in the directory, this short-term fix made it immediately clear in the online directory if a facility's license had expired.

[19] As we discuss further in Chapter 4, MDH has regularly allowed facilities to operate without a license, and its data on the dates that facilities have closed are sometimes unreliable.

[20] Users could access license start and end dates using the previous version of the directory, but only by clicking on links that appeared to lead to other information. Further, the previous version allowed users to download a complete list that contained no license dates.

Since fall 2025, MDH has made additional improvements to the online directory. MDH administrators reported they have removed all nonoperating facilities from the directory. Further, the department has added or is in the process of adding information that it had not provided previously, such as business type (for-profit or nonprofit), initial license date (when the facility first opened, as opposed to the start date of its current license), and whether the facility is operating with a conditional license. In addition, each facility entry now includes a link to the facility's listing of available services, which we discuss in more detail in the next section.

Given the steps MDH has already taken to improve its online directory of health care providers, we do not make a recommendation about the directory at this time.

Facility Listings of Services Offered

Under state law, all assisted living facilities must complete a standard disclosure form—the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA)—listing the services they can offer to prospective residents.[21] MDH designs the disclosure form, which assisted living facilities must provide to prospective residents.[22] MDH also requires facilities to provide the department a current copy of the disclosure form when they apply for or renew a license. The form's introductory paragraph explains its purpose:

> Prospective residents and their families can use this tool to determine if the assisted living facility can meet their needs, allow them to compare options among various settings, and make informed decisions about selecting an assisted living facility setting.

Facilities self-report the services they can provide on their disclosure forms; MDH does not ensure that the information provided on these forms is accurate.

Although UDALSA forms are intended to allow consumers to "make informed decisions" about assisted living care, the information facilities list on these forms may not always be accurate. MDH licensing review staff do not verify the information provided by facilities in their UDALSAs; they only ensure that facilities have submitted the form with their license applications as required. Similarly, MDH inspection staff only review the care that is being provided at the time of the inspection. They do not assess whether facilities have the capacity to provide all of the services they claim on their UDALSAs.

As part of our evaluation, we reviewed MDH's files for 75 assisted living facility applications for initial license, license renewal, or change of ownership.[23] Several of the

[21] *Minnesota Statutes* 2025, 144G.40, subd. 2.

[22] *Minnesota Statutes* 2025, 144G.40, subd. 2.

[23] About 90 percent of the files we reviewed included a UDALSA submitted in connection with the application. MDH was able to provide us nearly all of the missing UDALSAs when we asked, but we could not confirm whether the department received them at the time of the associated applications.

UDALSAs we reviewed contained internally inconsistent information about the availability of care. For example, we identified at least seven UDALSAs that indicated on one part of the form that a registered nurse or a licensed practical nurse was on site at all times, but in a different part of the form noted that nurses were on site only part time (or in one instance, only on an on-call basis). Both of these statements could not be accurate.

Based on our file review, we also agreed with several observations made in an April 2025 report issued by the Office of the Ombudsperson for Long Term Care.[24] That report noted that some of the items MDH listed on the UDALSA are poorly defined, leaving it up to the facilities to decide what constitutes "full-time" and "part-time" staffing or "semi-private" living arrangements.[25] We also agreed with the Ombudsperson's observation that MDH has allowed facilities to leave parts of the UDALSA incomplete and to write in noncommittal answers like "it varies" when a number or a yes/no answer is clearly requested.[26]

MDH does not provide disclosure form information to the public in a manner that facilitates comparisons between facilities.

As noted previously, one of the UDALSA's stated purposes is to enable consumers to "compare options among various settings." However, MDH distributes UDALSAs in a format that makes it unnecessarily difficult for consumers to use them for this purpose.

MDH publishes UDALSAs to its website as individual documents. Thus, a consumer may need to download and view many documents to make comparisons and search for the availability of services. For example, suppose a prospective assisted living facility resident wishes to find a facility in Dakota County that offers complex wound care. To use the UDALSAs to determine which facilities in the county offer this service, the prospective resident would have to review separate UDALSAs for each of the over 200 assisted living facilities in Dakota County and search each one to locate the relevant information.

RECOMMENDATION

MDH should improve the accuracy and usefulness of the information on the disclosure forms that assisted living facilities complete.

Rather than merely accepting and republishing the UDALSAs that facilities submit during the licensing process, MDH should take steps to check that the UDALSA information is internally consistent, complete, and plausible. MDH should also clarify the definitions of terms used in the form so facilities do not misunderstand what information they are being asked to submit and the information provided by different facilities is comparable.

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[24] Alice Hewitt, Office of Ombudsman for Long Term Care, *Uniform Disclosure of Amenities and Services: An Analysis of Information Disclosed Regarding Facilities, Staffing, and Care Practices in Minnesota Assisted Living Facilities*, April 2025, https://mn.gov/ooltc/assets/Uniform%20Disclosure%20of%20Amenities%20and%20Services%20Project%20Report_tcm1168-583694.pdf, accessed July 16, 2025.

[25] Hewitt, *Uniform Disclosure of Amenities and Services*, 16–17.

[26] Hewitt, *Uniform Disclosure of Amenities and Services*, 16–17.

Additionally, MDH should make the information provided in the forms searchable online, so that consumers can select various services and amenities that are listed in the forms and generate a list of the facilities that offer them. MDH could do so by manually entering the information it receives into a database, but we think it would be more efficient to redesign the disclosure form as a web form so that facility responses feed into a database automatically. Using an electronic data gathering method would also enable MDH to create automated rules that would help prevent facilities from submitting incomplete or internally inconsistent UDALSAs.

Inspection Reports

In order to provide assisted living residents and their families transparency about its enforcement activities, MDH posts on its website inspection reports that its staff generate after facility inspections. Inspection reports are generally structured as a list of violations. The report lists the statutory requirement, describes the situation or conditions that the inspectors found, and reports the severity level of the violation (one to five) and the time frame for correcting it.[27] When there are violations, MDH often attaches to the inspection report additional information from one or more follow-up inspections, in which inspectors indicate whether the facility had corrected the noncompliant situation or condition.

Information from inspections can be helpful to residents, prospective residents, and their families, who can learn what facilities need to improve. However, as with the UDALSAs, MDH does not organize this information in a way that is helpful for consumers.

MDH posts inspection reports for individual facilities online but does not provide key summary information for consumers and the public.

MDH posts facility inspection reports on its website in their entirety. Doing so provides a great deal of information about a facility's violations and about the steps that the facility has taken to address those violations.

However, MDH inspection reports are often long and quite detailed. The violations listed in a report are not necessarily in the order of seriousness, and reports may be 20–40 pages or more. A consumer interested in comparing the compliance record of multiple facilities would likely have to read at least 100 pages of documentation.

The inspection reports are accompanied by an overview letter that consists mostly of standard language that accompanies every inspection report. The letter includes a listing of each fine and the category of the associated violation (for example, fire code or medication administration) for which the facility is cited.

[27] In Chapter 2, we referred to severity levels of one to four when referring to data from *past* inspections. MDH shifted from four severity levels to five in 2025 after a change in law. *Laws of Minnesota* 2025, First Special Session, chapter 3, art. 1, secs. 73–75, codified in *Minnesota Statutes* 2025, 144G.31, subds. 2, 4, and 5.

The lack of summary information in the inspection reports contrasts strongly with the clear summary information provided at the beginning of MDH's investigation reports into maltreatment allegations. Unlike the inspection reports, MDH maltreatment investigation reports begin with a narrative summary of the allegation received, whether the allegation was substantiated, and a summary of what the investigator found.[28] A consumer can usually read the first few paragraphs of an investigation report and quickly gain a clear understanding of MDH's investigative findings.

RECOMMENDATION

MDH should provide online summary information about its inspection findings.

MDH should continue to post its full inspection reports online; doing so provides important transparency. However, the department could do more to make the key findings of those reports easily accessible to the public. Specifically, MDH should develop a summary listing of the cited violations resulting from each inspection and post the summary online with the relevant inspection report.[29] We offer one possible example in Exhibit 3.3, which includes a brief description of each violation, its severity level, and whether a fine was imposed. However, we can envision many possible summary formats. Further, MDH would need to consider how and whether to adjust the summary to account for follow-up inspections or if a facility successfully appeals a fine.

Exhibit 3.3
Sample Inspection Summary

Severity Level	Category	Summary	Fine
3	Background Studies	Maintenance director, who had direct access to residents, did not have a completed background study	$1,000
2	Disaster Planning	Facility's emergency preparedness plan did not contain all the required elements	–
2	Fire Code	Emergency exit doors from memory care unit required a code to unlock and could not be opened instantly in an emergency	$500
2	Fire Code	Trash chute door to dumpster was wedged open, which could allow a fire in the dumpster to spread up the chute	–
2	Food Code	Cleaning solution used in kitchen did not have sufficient ammonia concentration; raw eggs were stored too close to ready-to-eat lettuce	–
2	Medication Documentation	Facility staff did not accurately transcribe a prescription for a resident	–
2	Resident Records	Facility staff did not properly update several resident records with information from nursing assessments	–

Source: Office of the Legislative Auditor, summary of a selected 22-page 2026 inspection report.

[28] An MDH administrator told us that MDH's maltreatment investigation reports contain these summaries because they must meet the requirements of *Minnesota Statutes* 2025, 626.557, subd. 12b(b). Investigation reports regarding complaints that do not involve maltreatment do not contain these summaries.

[29] MDH could choose to incorporate this information into the overview letter it sends to the facility, which would then be posted online with the rest of the inspection report. However, it could also post this information online in another format.

OLA

Chapter 4: Fragmented Oversight

When it established assisted living facility licensing in 2019, the Legislature gave the Minnesota Department of Health (MDH) primary responsibility for oversight. All assisted living facilities must hold an MDH license and are subject to unannounced inspections by MDH staff to ensure they follow state requirements. MDH also investigates maltreatment reports and other complaints and may require facilities to take certain corrective actions.

However, the Legislature also gave certain assisted living oversight responsibilities to state agencies other than MDH. Having more than one agency with related—and even overlapping—oversight responsibilities can create challenges of coordination. In this chapter, we focus on MDH's interactions with two agencies that share assisted living oversight responsibilities: the Board of Executives for Long Term Services and Supports and the Department of Human Services (DHS).

Key Findings in This Chapter

- MDH does not have sufficient authority to enforce the requirement that assisted living facilities employ licensed assisted living directors.
- MDH has not provided DHS with clear information about the license status of some assisted living facilities, making it challenging for DHS to verify it is paying eligible providers.
- DHS does not verify that the number of residents for which a facility receives payment is within the facility's licensed capacity.
- DHS processes for verifying Medical Assistance payments for assisted living services may not catch certain types of misbilling.

Oversight of Assisted Living Directors

In 1969, the Legislature created the Board of Examiners for Nursing Home Administrators to license individuals operating nursing homes.[1] When the Legislature instituted licensing for assisted living facilities in 2019, it extended the jurisdiction of the board to include the directors of assisted living facilities and renamed it the Board of Executives for Long Term Services and Supports (BELTSS).[2]

Minnesota law requires every assisted living facility to employ an assisted living director whom BELTSS has licensed or permitted as an assisted living director and who is designated as the facility's "director of record" with BELTSS.[3] Statutes define the

[1] *Laws of Minnesota* 1969, chapter 770.

[2] *Laws of Minnesota* 2019, chapter 60, art. 4, secs. 6–15, codified in *Minnesota Statutes* 2025, 144A.19–144A.291.

[3] *Minnesota Statutes* 2025, 144G.10, subd. 1a. BELTSS issues "permits" to individuals that meet minimal qualifications but have not met all of the requirements for licensure. Permit holders may serve as the director of record for an assisted living facility for no more than one year while completing the licensure requirements. *Minnesota Rules* 2025, 6400.7080. For the sake of simplicity, we refer only to "licenses" and "licensed directors" for the remainder of this section, but the same information applies to permits and permitted directors.

Assisted Living Director Responsibilities

Assisted living directors are "responsible for the general administration and management" of the assisted living facility and overseeing its day-to-day operations, including:

(1) Ensuring services are provided to residents.

(2) Maintaining compliance with laws and rules.

(3) Developing and implementing policies and procedures.

(4) Ensuring residents' rights are respected.

(5) Maintaining buildings and grounds.

(6) Recruiting, hiring, training, and supervising staff.

(7) Ensuring the development, implementation, and monitoring of a plan of care for each resident.

— *Minnesota Rules* 2025, 6400.7050(G)

assisted living director as the "person who administers, manages, supervises, or is in general administrative charge of an assisted living facility"; state rules outline the director's responsibilities, as shown in the box at the left.[4]

To obtain a license, prospective assisted living directors must demonstrate their capability to oversee an assisted living facility so that the facility meets standards in state law. Licensees must:

- Complete at least 120 hours of training.
- Complete at least 320 hours of field experience under the guidance of a mentor.
- Have at least six months of work experience in a long-term care setting.
- Pass national and state examinations.
- After licensure, complete 30 hours of continuing education every two years.[5]

Assisted living directors may serve as the director of record for more than one facility simultaneously.[6] However, BELTSS must explicitly approve such arrangements; it gives directors "shared director" licenses specific to each additional facility they direct. In determining whether to grant such licenses, BELTSS must consider the director's education, experience, and record, and the size, location, staffing, and ownership of the facilities.[7] Individuals may not serve as the director of record for more than five facilities simultaneously.[8]

MDH and BELTSS share responsibility for ensuring that every assisted living facility has a qualified director of record. The two entities take different approaches based on their regulatory responsibilities.

MDH licenses *facilities*. It requires that applicants for provisional licenses and license renewals identify a licensed assisted living director for each facility. Further, when MDH staff inspect a facility, they check that the assisted living director holds a current license with BELTSS and that BELTSS lists the individual as the director of record for

[4] *Minnesota Statutes* 2025, 144G.08, subd. 6; and *Minnesota Rules* 2025, 6400.7050(G).

[5] This listing is not comprehensive; assisted living directors must meet other criteria, such as completing a criminal background check. BELTSS may waive some requirements if an applicant already has a nursing home administrator license or an assisted living director license from another state. *Minnesota Rules* 2025, 6400.7005, 6400.7030, 6400.7045, and 6400.7090.

[6] *Minnesota Rules* 2025, 6400.7085.

[7] *Minnesota Rules* 2025, 6400.7085, subp. C.

[8] *Minnesota Rules* 2025, 6400.7085, subp. D.

the facility. If the facility does not have a licensed director, or if the director is not listed by BELTSS as that facility's director of record, MDH issues a correction order to the facility.

BELTSS licenses *individuals*. It requires that individuals seeking an assisted living director license meet the minimum requirements for licensure. It requires directors to notify BELTSS whenever they start or stop working as the director of record for a facility.[9] BELTSS can withhold renewal of a director's license if the director stops meeting its requirements (for example, by failing to complete continuing education), and it can suspend or revoke a license for individual misconduct.

MDH does not have sufficient authority to enforce the requirement that assisted living facilities employ licensed assisted living directors.

BELTSS may notify MDH when it is aware that a director has left a facility, but it does not take further action regarding the facility; its regulatory responsibility applies to individuals, not to facilities. However, MDH has limited ability to act on this information due to statutory constraints.

State law requires facilities to notify MDH if certain information from their licensing application changes, but the information specified in law does not include the identity of the assisted living director.[10] Given this statutory provision, MDH cannot require facilities to update their applications with the name of a new assisted living director, even if the department has been informed that the previous director has departed.

MDH does check whether the facility has a licensed assisted living director when the facility next renews its license or undergoes an inspection.[11] However, relying on this enforcement mechanism is inadequate. Data that BELTSS provided to our office in August 2025 indicated that at that time, 82 assisted living facilities did not have a director of record. Further, when we surveyed assisted living directors, we found that the directors of record listed by BELTSS for at least another 87 facilities were no longer directing those facilities (most said they were not directing any facility), or were unreachable at the email address on file with BELTSS.[12] Combining the two groups, about 169 assisted living facilities (or about 7 percent of all facilities) may not have employed a director of record designated with BELTSS, as required by state law.[13]

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[9] Some individuals maintain an assisted living director license without serving as the "director of record" for any facility.

[10] *Minnesota Statutes* 2025, 144G.18, subd. 1.

[11] Through July 2025, MDH cited at least 38 facilities for not having a licensed assisted living director listed as the director of record at the time of inspection; most violations were issued in the first two years after licensing began.

[12] State law requires assisted living directors to maintain an active email address on file with BELTSS. *Minnesota Rules* 2025, 6400.6100, subp. 1; and 6400.7050(B).

[13] *Minnesota Statutes* 2025, 144G.10, subd. 1a.

RECOMMENDATION

The Legislature should consider giving MDH additional authority to monitor compliance with the statutory requirement that facilities employ a licensed assisted living director.

When developing assisted living facility licensing, the Legislature sought to ensure that facilities would be managed by qualified individuals with appropriate training. However, the separate laws related to the overlapping responsibilities of BELTSS and MDH make it difficult to effectively enforce this expectation. Licensed assisted living directors must notify BELTSS within five working days of leaving employment as the director for an assisted living facility.[14] But the facilities they worked at are not required to notify MDH of a vacancy or a change in the assisted living director position. As statutes are currently written, MDH cannot require facilities to provide information to the department demonstrating they have retained a new licensed director.

Our finding that as many as 7 percent of facilities may not have had properly designated directors of record indicates that further steps to enforce the law are warranted. The Legislature should consider giving MDH clearer authority to ensure that facilities promptly replace assisted living directors when a vacancy occurs.

In the meantime, MDH should at least notify facilities that they are required to retain a new licensed assisted living director whenever it receives information from BELTSS that a previous director has left their position.

MDH has not enforced the legal requirement that individuals serving as the director for more than one facility simultaneously must receive approval from BELTSS.

During its licensing application and change of ownership processes, MDH checks to make sure that the person listed as the assisted living director has a current BELTSS license. As long as an individual has a current license, MDH considers the facility to have met the statutory requirement to employ a licensed assisted living director—even if the individual that the assisted living facility lists in its application is already listed by BELTSS as a director for another facility. MDH does not check whether BELTSS has approved the director to direct an additional facility.

MDH administrators told us that the department cannot check whether BELTSS has approved an individual to direct an additional facility during the provisional license approval process because BELTSS does not designate a director of record until the facility itself is licensed. However, this argument does not apply to license renewals, changes in ownership, or facility relocations. For newly licensed facilities, MDH could check BELTSS's records to ensure that the individual listed in the license application

[14] *Minnesota Rules* 2025, 6400.7050, subp. C.

has become the director of record when the facility notifies MDH it has begun serving residents.[15] It does not do so.

We also encountered at least one instance where MDH approved a license application for an assisted living facility even though the assisted living director designated in the application was ineligible because they already were the director of record for five other facilities. Verification documentation that MDH retained in its files showed the individual was the director of record for the five other facilities, so MDH staff should have realized the individual could not legally direct a sixth facility.

RECOMMENDATION

MDH should ensure that assisted living facilities that share a licensed assisted living director have BELTSS approval for the sharing arrangement.

BELTSS staff told us that it is important to limit the number of assisted living facilities a single person directs because it is difficult for one person to effectively run multiple facilities and provide a sufficient on-site presence at each facility. When assisted living facility applications list an assisted living director who already directs another facility, MDH should verify that BELTSS has approved that individual to add direction of the new facility to their existing responsibilities.

Oversight of Medical Assistance Payments

As we briefly discussed in Chapter 1, both MDH and DHS play a role in overseeing assisted living facilities. MDH licenses facilities and ensures that buildings, staffing, food preparation, care provision, and other operational activities meet the requirements of state law.

DHS is an important funder of assisted living services. Thousands of assisted living residents pay for assisted living expenses through Minnesota's Medical Assistance program. DHS is responsible for issuing these payments and works with local lead social services agencies to ensure that residents are receiving the "customized living" services for which it issues payments.[16] Not every assisted living facility receives payments from DHS, but a majority do—thus, most assisted living facilities in the state must meet both MDH and DHS requirements.

Similar to the relationship between MDH and BELTSS we described in the previous section, MDH and DHS have different approaches to oversight based on their differing responsibilities. MDH's oversight focuses on the *facility* providing services. MDH ensures that the facility has the capacity to provide appropriate care to its residents.

[15] Newly licensed facilities are required to notify MDH as soon as they begin serving their first resident. *Minnesota Statutes* 2025, 144G.16, subd. 2(b).

[16] Customized living is the DHS term for the Medical Assistance-funded services typically provided in an assisted living setting. There is much overlap between the DHS definition of customized living and the statutory definition of assisted living, but they are not exactly the same.

DHS's oversight focuses on the *individual* receiving care and the *services* that individual receives. DHS and local lead social services agencies ensure that the program participant is eligible to receive public assistance and receives services matching their needs.

Verifying Valid Licensure

DHS is responsible for ensuring that facilities that provide customized living services are eligible to receive payments for those services. MDH-licensed assisted living facilities are generally eligible to provide customized living services as long as they meet certain criteria; facilities with other types of licenses are generally ineligible.[17] Thus, effective and accurate communication between MDH and DHS about facilities' licensure status is important—particularly because assisted living facilities open and close frequently. Between January 2022 and July 2025, new assisted living facilities opened at a rate of 4.1 per week, and existing facilities closed at a rate of 2.7 per week.

MDH has not provided DHS with clear information about the license status of some assisted living facilities, making it challenging for DHS to verify it is paying eligible providers.

MDH's data regarding license start and end dates are not always clear. MDH provides DHS with listings of licensed assisted living facilities and the start and end dates of their licenses so that DHS can verify the facilities are eligible to receive payments. But MDH has somewhat routinely allowed assisted living facilities to remain open after their licenses expire. These facilities operate with MDH permission, but without a license. In many instances, these facilities eventually renew their licenses—at which point MDH sets the starting date of the new license to match the end date of the previous license so their data show no gap in licensure.

There are several scenarios in which MDH may allow assisted living facilities to remain open without a license; a common one is that a facility is working on renewing its license, but has not yet done so due to a technical issue. MDH's flexibility in allowing the facility to remain open avoids the disruptions of closure and resident relocation in circumstances where MDH expects a facility to successfully resolve its licensing issue.

However, when an assisted living facility stays open for some time without an active license, its eligibility status to receive DHS payments for customized living becomes unclear. DHS staff have had to rely on updates from MDH staff to determine whether facilities are legally operating because facilities listed as having expired licenses in the data they receive from MDH may later have their licenses renewed.[18]

Even more challenging are situations where MDH allowed a facility to remain open without a license, but then the facility closed without ever successfully renewing its license. In such circumstances, it can be unclear at what point the facility ceased operating or ceased to become eligible to receive DHS payments. In a handful of circumstances, MDH staff told us they simply did not know on what date a facility actually closed.

[17] Providers with comprehensive home care licenses may provide customized living services in certain affordable housing settings. *Minnesota Statutes* 2025, 256S.20, subd. 1(a).

[18] BELTSS staff also told us that they have had difficulties deciphering MDH licensing data.

Our analysis of DHS and MDH data showed that a small number of facilities received DHS payments for services provided after their MDH assisted living facility licenses had expired, and the facility never obtained a license renewal. We were unable to determine whether these payments were improper because of the poor quality of MDH's data.

RECOMMENDATION

MDH should record clear start and end dates for assisted living facility licenses.

MDH's practice of allowing facilities to remain open without a license for an indeterminate length of time and its willingness to later set license start dates to match the end dates of a previous license could potentially lead DHS to issue payments to facilities that were unlicensed, or even closed, on the dates covered by the payments.

MDH should create a more formal process for managing the occasional need to bridge a gap between the end of one licensing period and the start of the next. One approach could be to create a license extension or waiver, which could be granted to facilities for a month or two when needed to bridge a gap between the end of one license and the start of the next. If the extension or waiver expires, the facility would have to obtain another or close. MDH could then provide information about those extensions or waivers—which would have fixed start and end dates—to DHS.

Verifying Resident Capacity

MDH licenses assisted living facilities for a specific resident capacity, the maximum number of residents that the facility is allowed to serve at any one time. If facilities wish to change their resident capacity, they must seek approval from MDH.

DHS does not verify that the number of residents for which a facility receives payment is within the facility's licensed capacity.

When a provider submits a request for payment, DHS checks that the payment request is consistent with the approved services for the individual recipient. If the individual is eligible for the service and the provider is an eligible provider, DHS processes the payment. However, because DHS processes payments separately for each individual, there is no step at which DHS checks the claims it has received against the total capacity of the assisted living facility.

According to DHS data, over 100 assisted living facilities received DHS payments for more individuals than their licensed capacity during Fiscal Year 2024. For example, one facility had a licensed capacity of only 6 residents, but received Medical Assistance payments for 18 residents during a single month in 2024.[19]

[19] All the residents received services during the entire month; it was not the case that any residents moved out during that month and other residents moved in.

It is unclear whether any of these payments were for services that were not actually provided. In at least 85 percent of instances that we identified where an assisted living facility received payments for more residents than its capacity, the provider that owned the facility and received the payments also owned and operated other facilities. Thus, the extra residents whose care DHS paid for may have actually resided in another facility operated by the same owners.

We contacted six assisted living providers that had received payments for providing services to more residents than the facility's capacity and requested lists of residents served by *all* of their facilities over an 18-month period.[20] In all cases, mismatches between payments and residents in DHS data were explained by some residents living in a different assisted living facility owned by the same provider.

Nonetheless, without separately checking each assisted living facility that received payments for more residents than it had the capacity to serve, it is impossible to know with certainty whether all the claims that DHS paid were legitimate.

MDH has not always provided accurate information to DHS regarding facility capacities.

Although DHS should take steps to verify payment claims, inaccurate MDH data hinders its ability to do so. At times, MDH has not accurately recorded information in its data systems about changes to facility capacity, nor has it made accurate facility capacity data available to DHS.

For example, a facility may hold an assisted living license that begins in March and lasts for one year, allowing it to serve four residents. In September, the facility decides to increase its capacity to five residents and requests that MDH change its license accordingly. MDH does so—but in its data system, it changes the facility capacity for the entire time period of the license. Thus, the facility appears to have had the capacity to serve five residents starting in March. If DHS checked payment claims against the facility capacity information from MDH, it would inaccurately conclude that the facility had a licensed capacity of five for the entire period.

DHS needs accurate data that is historical, not just current as of the date that information is requested. Medical Assistance providers may submit claims for payment for up to a year after the date of the service.[21] Thus, DHS needs to be able to determine what a facility's capacity was on past dates in order to verify the validity of provider claims filed for a given facility.

[20] A seventh provider we contacted had changed ownership and no longer had resident records covering the time period.

[21] *Minnesota Rules* 2025, 9505.0450, subp. 2.

RECOMMENDATIONS

- **DHS should ensure that it does not pay assisted living facilities for more residents than the facilities are authorized to serve.**
- **MDH should create recordkeeping processes that accurately indicate an assisted living facility's current and historical resident capacity.**

DHS obtains licensing information from MDH about licensed assisted living facilities. DHS should configure its claims processing procedures to check whether a provider is seeking payments for more individuals than the facility is licensed to serve at a given time. If so, DHS should take additional verification steps to ensure that the claims are valid.

Without accurate information about licensed facility capacities, DHS is at increased risk of paying invalid provider claims. MDH does not accurately record information about assisted living facilities that change their capacities in the middle of a license period. MDH should modify its data systems to accurately record the dates on which changes to licensed facility capacities take effect. It should then provide accurate facility capacity data to DHS.

Verifying Services Provided

In the previous two sections, we raised concerns that DHS may be at risk of paying for services that were not actually provided or that the provider was ineligible to provide. We have made recommendations that MDH and DHS improve their data and verification systems to limit the risk of such payments occurring.

However, those improvements would be unlikely to catch instances where a Medical Assistance recipient is *underserved*—that is, when the provider provides some services to the recipient, but the provider claims (and is paid for) more services than it actually delivers.

DHS bases its payments on individual service agreements that are approved by county case workers. The service agreement designates the services the recipient is eligible to receive and the provider who will provide the services. When a provider submits a request for payment, DHS checks that the payment request is consistent with the approved services in the recipient's service agreement.

DHS processes for verifying Medical Assistance payments for assisted living services may not catch certain types of misbilling.

As we noted earlier in this chapter, MDH's inspection process is focused on the *facility* license. MDH staff examine the qualifications of facility staff and check whether the facility's operating practices are consistent with state law. However, MDH does not examine whether individuals within the facility are receiving care consistent with the payments the facility receives from DHS.

DHS's oversight processes, meanwhile, rely on county social services case managers. The case manager's responsibility is to ensure that *individual* recipients are at a facility that can provide appropriate care. However, individuals at the same facility could be assigned to different case managers, each of whom would separately determine whether their client was at a facility that can provide appropriate services.

If a facility is underserving residents as a group (for example, by not staffing sufficiently to provide all of the services the state pays for simultaneously), there is a risk that neither DHS nor county case managers would identify the problem. When a case manager makes an on-site visit, they only examine the services being received by their individual clients, not the services received by all Medical Assistance recipients at the facility. One county social services administrator with whom we spoke described a small assisted living facility at which three of her case managers had clients. Based on the combination of individual service agreements, facility staff should have been providing services to at least one of the three at all times. However, she found no services were being provided at a time she made an unannounced visit to the facility.

Determining whether such overbilling actually occurred was beyond the scope of our evaluation, which was primarily focused on MDH's responsibilities. However, our limited review of DHS data and procedures suggested that there is a risk that such overbilling could occur without detection.

RECOMMENDATION

MDH and DHS should work together and with the Legislature to authorize MDH inspectors to assist in verifying whether assisted living facilities are providing state-funded services.

To verify whether an assisted living facility is providing all the services for which it receives Medical Assistance payments, a trained observer would need to visit the facility to evaluate the facility's care for all its residents. Helpfully, a process already exists in which trained staff make unannounced visits to assisted living facilities—MDH's existing inspection process, which utilizes nurses as inspectors.

MDH and DHS should work together to take advantage of existing MDH inspections to add another layer of oversight for payments DHS makes to assisted living facilities. In addition to their review of a facility's compliance with licensing laws, MDH inspectors could also evaluate whether individuals at the facility whose care is funded by DHS are receiving the services for which the state is paying. Such an arrangement between the two departments already exists for nursing homes.

MDH administrators told us that such a change to the MDH inspection process would be feasible for MDH's inspection staff to implement. However, this change would require the two departments to coordinate with each other and could require additional statutory authority and funding from the Legislature. Most notably, MDH inspection staff would need to have up-to-date information on DHS recipients that reside in the assisted living facilities they inspect. Developing a process to reliably share such data could be challenging because the departments' two data systems do not categorize and identify assisted living facilities in the same way.

Further, as we discussed in Chapter 2, MDH has struggled to meet its existing obligations to inspect all facilities within statutorily required time frames. Adding duties to the work of MDH inspectors could lengthen inspections, making it even more difficult for the department to catch up on its inspection backlog. Thus, it is possible that MDH's Health Regulation Division could need additional resources to fully implement this recommendation.

OLA

List of Recommendations

- The Minnesota Department of Health (MDH) should ensure it retains documentation used to verify information provided by license applicants. (p. 18)

- MDH should comply with statutorily required timelines for assisted living facility inspections. (p. 24)

- MDH should establish standards for imposing licensing sanctions on assisted living facilities. (p. 29)

- The Department of Human Services (DHS) should improve its assisted living report card methodology; if necessary, it should request additional data-gathering authority from the Legislature. (p. 37)

- MDH should improve the accuracy and usefulness of the information on the disclosure forms that assisted living facilities complete. (p. 41)

- MDH should provide online summary information about its inspection findings. (p. 43)

- The Legislature should consider giving MDH additional authority to monitor compliance with the statutory requirement that facilities employ a licensed assisted living director. (p. 48)

- MDH should ensure that assisted living facilities that share a licensed assisted living director have approval from the Board of Executives for Long Term Services and Supports (BELTSS) for the sharing arrangement. (p. 49)

- MDH should record clear start and end dates for assisted living facility licenses. (p. 51)

- DHS should ensure that it does not pay assisted living facilities for more residents than the facilities are authorized to serve. (p. 53)

- MDH should create recordkeeping processes that accurately indicate an assisted living facility's current and historical resident capacity. (p. 53)

- MDH and DHS should work together and with the Legislature to authorize MDH inspectors to assist in verifying whether assisted living facilities are providing state-funded services. (p. 54)

OLA

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 1, 2026

Ms. Judy Randall
Legislative Auditor
Office of the Legislative Auditor
658 Cedar St. Room 140
Centennial Office Building
St. Paul, MN 55155-1603

Dear Ms. Randall,

Thank you for the opportunity to review and respond to recommendations in the recent program evaluation of Assisted Living Facility Licensure at the Minnesota Department of Health (MDH). One of the goals of the MDH Health Regulation Division (HRD) is to protect, maintain, and improve the health of all Minnesotans who receive assisted living services. HRD does this through licensure, inspections (onsite surveys), enforcement, and communication with providers and the public on the issues related to assisted living laws and regulation. Assisted living facility licensure authority was implemented in 2021, and in that time, we have made considerable progress in this important work.

MDH greatly values and appreciates your feedback as we identify areas for improvement. We agree that strong oversight of and compliance in our assisted living facilities is critical to the health and safety of Minnesotans in their care. We will use this opportunity to continue to ensure our quality assurance and quality control processes are well-designed, consistent, and effective. The report also serves as an important guide for future legislative policy proposals.

MDH appreciates the time and attention of key partners at the Board of Executives for Long Term Services and Supports (BELTSS), the Department of Human Services (DHS), the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, county social services agencies, and the providers and advocates who took the time to provide honest, candid, and informative feedback to the survey used in this evaluation. The survey results reflect the strong relationships and licensing processes we have strived to create.

We also appreciate the opportunity to respond to specific recommendations. To that end, the following is a summary of our responses:

Recommendation: MDH should ensure it retains documentation used to verify information provided by license applicants (Recommendation #1 of Chapter 2).

Response: We have strengthened and regularly review our quality controls to ensure that documentation is on file for license applications.

In September of 2025, MDH reviewed our procedures related to document verification and capture with our credentialing team to ensure understanding of how and why documents should be preserved. These processes are documented in our standard operating procedures (SOPs) and incorporated into training for new employees.

MDH has also added a new quality assurance check. Our Licensing Supervisor is spot checking 5-7% of application files to confirm all documents have been verified and captured. The goal is to increase this number to 10% for all application files once staffing levels support this level of review by November 2026.

Recommendation: MDH should comply with statutorily required timelines for assisted living facility inspections (Recommendation #2 of Chapter 2).

Response: MDH has made great strides in improving inspection rates since assisted living licensure went live in August 2021. Two factors impacted the delay of the first 24-month inspection cycle. One, many of our nurses were reassigned during COVID due to MDH emergency response needs. Two, a much higher number of facilities sought new assisted living licenses under the new law than anticipated, which necessitated MDH to seek a legislative appropriation to obtain more staff. The first 24-month inspection cycle took 38 months to complete from August 2021 to October 2024. MDH is anticipating completing the second 24-month inspection cycle that began in November 2024 significantly faster than the first round of assisted living inspections with an estimated completion date of early 2027. Our goal is to inspect all providers within the 24-month statutorily required timeline.

Recommendation: MDH should establish standards for imposing licensing sanctions on assisted living facilities (Recommendation #3 of Chapter 2).

Response: Implementing this recommendation requires changes to statute or rule. MDH is evaluating available options to implement this recommendation consistent with applicable law.

Recommendation: DHS should improve its assisted living report card methodology; if necessary, it should request additional data-gathering authority from the Legislature (Recommendation #4 of Chapter 3).

Response: MDH is working with DHS on ways we can improve the value, breadth, and transparency of the assisted living report card.

Recommendation: MDH should improve the accuracy and usefulness of the information on disclosure forms that assisted living facilities complete (Recommendation #5 of Chapter 3).

Response: MDH is working to improve the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) form to make the data more user-friendly for consumers who would like to search for and compare services between facilities. The updated form will be designed in a way that requires clearer descriptions of services provided and prevents incomplete or erroneous entries. MDH will solicit stakeholder feedback (as required by statute) and incorporate these changes into the updated form and format. This is to be completed in early 2027.

Recommendation: MDH should provide online summary information about its inspection findings (Recommendation #6 of Chapter 3).

Response: MDH recognizes the value of a summary information page in addition to a full inspection report. MDH will work to determine how best to incorporate a summary information page into the report with completion by early 2027.

Recommendation: The Legislature should consider giving MDH additional authority to monitor compliance with the statutory requirement that facilities employ a licensed assisted living director (Recommendation #7 of Chapter 4).

Response: Minnesota Statute 144G.10, subd. 1a requires each assisted living facility to employ an assisted living director licensed by BELTSS and that the licensed individual is affiliated as the director of record with BELTSS. Assisted living facilities are also required to disclose information verifying they are compliant with this requirement upon initial licensure and upon annual licensure renewal. MDH currently monitors compliance with this requirement under MDH's survey and investigation authority, and if this requirement is not met by the facility, a correction order is issued. MDH is evaluating legislative proposals for 2027 to clarify this area of statute.

Recommendation: MDH should ensure that assisted living facilities that share a licensed assisted living director have BELTSS approval for the sharing arrangement (Recommendation #8 of Chapter 4).

Response: MDH does review and ensure that each assisted living facility has a licensed assisted living director (LALD) with the facility as its director of record during the licensing and inspection process. MDH writes correction orders when there is no LALD or director of record as an immediate correction order.

Minnesota Statute 144G.18 does not require a notification of change in LALD to MDH. MDH is reviewing a legislative change that would give the department more authority to act in between license application and inspection.

MDH is working with BELTSS to establish a process for BELTSS to review and approve LALDs on a provisional license, prior to the full license being issued. This process will address several issues: avoiding a protracted period where a LALD is of record with a facility that is not yet licensed; preventing situations where a provisional license is issued without a director of record; or preventing a LALD being listed as the director of record at more than five facilities.

Recommendation: MDH should record clear start and end dates for assisted living facility licenses (Recommendation #9 of Chapter 4).

Response: MDH is evaluating legislative proposals for the 2027 legislative session to help strengthen statute for when an assisted living facility has a delay or gap in renewal. If the license renewal is not completed on time, the existing facility license will appear as expired, although the renewal is in process. MDH currently has no authority for extensions, interim measures, or other changes in the expiration date to address these situations. Late renewals maintain an effective date of the day after the expiration date to maintain continuity of licensure and ensure continuity of care for residents. Minnesota Statutes Chapter 144G does not currently address a lapse in licensure.

An assisted living facility license can also end due to voluntary closure, denial of a provisional license, or revocation of a license. Continuity of care for the residents of the facility is critical, so a facility whose license was denied or revoked is permitted to continue operating while residents move to new service providers. Knowing that this can create uncertainty about the end date of the license, MDH conducted a review of our facility closure process, and in June 2026, we implemented additional tracking and oversight of facilities that are in the closure process, either voluntarily or due to an enforcement action or settlement. The changes include assignment of a nurse evaluator who will communicate with, and conduct onsite inspection as needed, of facilities in the closure process. This will provide more timely and accurate completion of the closure process, which will provide clear end dates.

Recommendations: 1) DHS should ensure that it does not pay assisted living facilities for more residents than the facilities are authorized to serve (Recommendation #10 of Chapter 4).

2) MDH should create recordkeeping processes that accurately indicate an assisted living facility's current and historical resident capacity (also Recommendation #10 of Chapter 4).

Response: MDH recently implemented a new system for recording capacity changes to capture the effective date of the change. This system is similar to the system for relocations where a new license record is created and a new license certificate is issued reflecting the new capacity. The effective date listed on the license certificate is the effective date of the capacity change and the expiration date is the same as the expiration

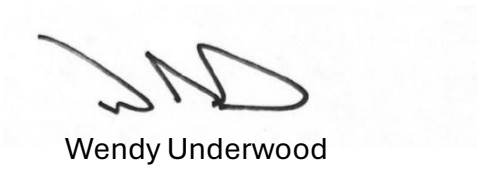
date listed on the previous license record (finishing the remainder of the license year under the new capacity). This data will feed directly into the online directory, which DHS accesses.

Recommendation: MDH and DHS should work together and with the Legislature to authorize MDH inspectors to assist in verifying whether assisted living facilities are providing state-funded services (Recommendation #11 of Chapter 4).

Response: MDH is actively working with DHS to strengthen verification of Medical Assistance payments for assisted living facilities within the MDH inspection process and what resources or additional authority may be needed to carry this out.

Thank you again for this opportunity to review and respond to these recommendations.

Sincerely,



Wendy Underwood
Deputy Commissioner

OLA

Minnesota Department of Human Services
Elmer L. Andersen Building
Temporary Commissioner John Connolly
Post Office Box 64998
St. Paul, Minnesota 55164-0998

September 1, 2026

Ms. Judy Randall
Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Ms. Randall:

Thank you for the opportunity to review and comment on your draft report titled *Assisted Living Licensing*. The Department of Human Services (DHS) agrees with the three recommendations that involve actions the department can take to improve assisted living services.

We continue to strengthen internal controls that help us detect and prevent fraud while improving program integrity and oversight of assisted living facilities so people can get the care they need. As identified in your report, we know we cannot do this alone. We welcome the opportunity to build on our work with the Legislature and state agency partners to make Minnesota a nationwide leader in the fight against fraud, waste and abuse.

Below is DHS' response to the recommendations.

Audit Recommendation 1

DHS should improve its assisted living report card methodology; if necessary, it should request additional data-gathering authority from the Legislature.

Agency Response

DHS is proud of its work on the groundbreaking Minnesota Assisted Living Report Card. This report card is one of the first of its kind in the nation, and it provides valuable information to the public about assisted livings that cannot be found anywhere else. This work has been guided by the literature on quality in assisted living settings and input from partners. We have engaged experts on long-term care quality at the University of Minnesota to develop a scientifically valid star rating system, based on currently available data. DHS is continuously looking for ways to improve and enhance the Assisted Living Report Card. For example, we have expanded the number of facilities included and added new quality measures to the tool since it launched.

DHS does display maltreatment investigations findings on its report card. We have not incorporated those findings into the star ratings themselves, because maltreatment findings are structured differently from licensing deficiencies and do not include comparable measures of scope and

severity. Therefore, we are concerned that combining maltreatment outcomes into the star ratings may not meet standards for validity, reliability and fairness if combined within a single star rating. Incorporating this data without a comparable structure could cause misleading comparisons across providers. However, DHS will continue to explore ways that we can account for maltreatment findings in the star ratings.

DHS would wholeheartedly welcome the development of additional data sources to expand upon the existing star rating system. The Office of the Legislative Auditor (OLA) rightly points out that Minnesota's Nursing Home Report Card includes additional measures not included in the Assisted Living Report Card, such as staffing measures or clinical outcomes. Statewide data sources for these types of measures in assisted living do not currently exist but could be developed with additional investment.

The OLA recommends that DHS increase the number of facilities that participate in resident quality of life and family satisfaction surveys by grouping together small settings that operate under common ownership. DHS will explore the feasibility of obtaining data that can identify settings that operate under common ownership. We will also analyze the scientific validity of this approach to determine how best to move forward.

Currently, the Assisted Living Report Card displays all providers with an active license. The list of providers is updated quarterly, and providers whose licenses are revoked are removed from the report card. DHS will work with MDH to explore the feasibility of identifying, within the report card, licensed assisted living facilities who have a conditional license, as well as the instances when a facility's license has been suspended or revoked.

Responsible Person: Assistant Commissioner, Aging and Disability Services Administration (ADSA)

Estimated Completion date: December 31, 2027

Audit Recommendation 2

DHS should ensure that it does not pay assisted living facilities for more residents than the facilities are authorized to serve.

Agency Response

We are pleased that your work did not identify any overpayments made to assisted living facilities. DHS' current requirement for case managers to prior authorize services such as assisted living services is an important tool to prevent these types of overpayments. We recognize that system edits limiting amounts paid to assisted living facilities based on their licensed capacity would further reduce the risk of overbilling and overpayments. We will explore the feasibility of implementing appropriate system payment edits based on licensed capacity established by MDH.

Responsible Person: Assistant Commissioner, Aging and Disability Services Administration (ADSA)

Estimated Completion date: December 31, 2027

Audit Recommendation 3

MDH and DHS should work together and with the Legislature to authorize MDH inspectors to assist in verifying whether assisted living facilities are providing state-funded services.

Agency Response

DHS welcomes the opportunity to continue working with MDH and the Legislature to improve oversight of services provided in assisted living settings.

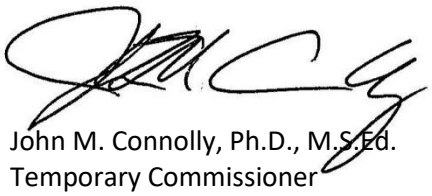
In 2026, DHS and the Governor proposed, and the Legislature authorized, new authority and funding to DHS to conduct oversight and monitoring of Medicaid-funded home and community-based (HCBS) residential services, including customized living services, which are provided in licensed assisted living settings. (Chapter 121, Article 9, Sections 35 and 49). Providers will be required to submit documentation to DHS about direct staffing hours provided to each person receiving Medicaid-funded HCBS services. DHS will then conduct audit activities to verify the information provided, with the goal of ensuring that people receive required services, and that rates paid to providers are aligned with services actually provided. This new activity will be a key component of DHS' strategy to improve oversight of assisted living providers and verify service delivery.

Responsible Person: Assistant Commissioner, Aging and Disability Services Administration (ADSA)

Estimated Completion date: January 1, 2029

We appreciated your staff's professionalism and dedicated efforts during this program evaluation. Our policy and practice are to follow up on all audit findings to evaluate our progress toward resolution. If you have further questions, please contact Susan Gamache, Director of Risk and Internal Controls, Minnesota Department of Human Services at (651) 431-2392.

Sincerely,



John M. Connolly, Ph.D., M.S.Ed.
Temporary Commissioner
State Medicaid Director

OLA

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Office of Minnesota Information Technology Services (MNIT), February 2019

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Community Benefit Expenditures at Nonprofit Hospitals, February 2025
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Office of Health Facility Complaints, March 2018

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Home- and Community-Based Services: Financial Oversight, February 2017

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Worker Misclassification, March 2024
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Southwest Light Rail Transit Construction: Metropolitan Council Oversight of Contractors, June 2023
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