Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 20, 2025

Licensee
Kayo Health Care Center LLC
5941 6th Street Northeast
Fridley, MN 55432

RE: Project Number(s) SL40979015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 23, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40979	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAYO HEALTH CARE CENTER LLC	5941 6TH STREET NORTHEAST FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40979015-0 On September 22, 2025, through September 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents; three (3) receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 23, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post an emergency disaster plan prominently and develop a written	0 680		

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0 680	Continued From page 4 emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's March 7, 2025, EPP lacked the required content: - missing resident plan and quarterly review; - description of the population served by the licensee; - the development of policies/procedures to address: - tracking of staff and patients; - medical documents; - use of volunteers; and - roles under a waiver declared by secretary; - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - means to providing information about the facility's occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and	0 680		

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0 680	Continued From page 5 - exercises to test the EPP at least twice per year, including unannounced drills using the EPP. On September 22, 2025, at 1:00 p.m., licensed assisted living director (LALD)-A stated he agrees some of the required items are missing from the EPP and they will updated the EPP to include all of the missing information. The licensee's Emergency Preparedness policy dated May 24, 2024, indicated the licensee's emergency preparedness plan will include all required elements of appendix Z. The licensee's Missing Resident policy dated May 24, 2024, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly. Changes to the plan will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subd. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 23, 2025, at 10:40 a.m., the surveyor toured the facility with registered nurse (RN)-C. During the facility tour, the surveyor observed the egress window in occupied resident sleeping room 1 was obstructed by the placement of a nightstand and personal items in front of the window. During the facility tour interview, RN-C verified the above listed observations. All paths of egress must provide unobstructed exiting. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 7 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content, maintain all parts of the plan as readily accessible, and	0 810		

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0 810	Continued From page 8 provide required drills. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2025, registered nurse (RN)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to develop the FSEP with site specific procedures for the facility and building occupants evident by the following: - The FSEP had been created using templates from third party providers. Pull fire alarms were inaccurately referenced. - The FSEP employee procedures were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym and failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. - The FSEP fire safety policy dated May 24, 2024, was limited to directing residents to stoop	0 810		

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0 810	Continued From page 9 or crawl to avoid smoke. The FSEP failed to include specific fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. - The FSEP evacuation procedures were limited to instructing employees to lead residents to the nearest safe exit. The FSEP failed to provide site specific actions for resident movement and evacuation during a fire or similar emergency evident by a lack of these procedures in the plan. - Residents requiring staff assistance in an emergency had been identified and these procedures were maintained electronically on the computer. These individualized evacuation procedures were not included with the printed copy of the FSEP. All parts of the FSEP must be maintained as readily available for accessibility. During an interview on September 23, 2025, at 12:15 p.m., RN-C verified the FSEP required revision. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees every other month evident by a review of completed fire drill reports. The surveyor requested records for evacuation drills completed between March and September 2025. The provided fire drill logs recorded drills in April and June. The fire drill schedule indicated drills were to be completed every month. During an interview on September 23, 2025, at 12:15 p.m., RN-C verified the drill logs did not support that fire drills were completed at a frequency of every other month.	0 810		

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0 810	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 11 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3 was admitted to the licensee and started receiving assisted living services on August 14, 2025. R3's record indicated R3 went to the emergency room and was admitted to the hospital on September 19, 2025, after a brief hospitalization R3 was discharged back to the licensee on September 23, 2025.	01060		

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01060	Continued From page 12 R3's record lacked an emergency relocation notification to include: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal; - notification to the resident, legal representative, and designated representative; - for residents who receive home and community-based services, the resident's case manager; and - notification to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On September 23, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of the emergency relocation notification that needed to be provided to the resident or that the Ombudsman should be notified if the resident has been gone from the facility more than four days. CNS-B stated they had not completed an emergency relocation for R3 but would start doing this for any resident that has an emergency relocation.	01060		

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	40979	A. BUILDING: _____ B. WING _____	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAYO HEALTH CARE CENTER LLC	5941 6TH STREET NORTHEAST FRIDLEY, MN 55432

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01060	Continued From page 13 The licensee's Discharge and Transfer of Residents policy dated May 24, 2024, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: - the resident - the resident's legal representative - the resident's designated representative - if the resident receives home and community-based services, the resident's case manager - if the resident has been relocated and not returned to licensee within four (4) days, the Office of Ombudsman for Long-Term Care - notice of the right to appeal the decision under 144G.54. The written notice shall include the following: - the reason for the relocation - name and contact information for the location to which the resident has been located and any new service provider - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities - if known, the approximate date range within which the resident is expected to return to the facility or a statement that the date is not currently known - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has a right to appeal the decision and contact information for the person to whom the resident should submit the appeal No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01060		

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01060	Continued From page 14 (21) days	01060		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document any follow-up procedures that were provided to meet the residents needs when medication was not administered as prescribed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760		

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	40979	A. BUILDING: _____ B. WING _____	09/23/2025

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01760	Continued From page 15 The findings include: R2 was admitted to the licensee on August 13, 2025, with diagnoses of cerebral infarction (stroke) and essential hypertension. R2's signed Service Plan dated August 14, 2025, indicated R2 received services to include medication administration, dressing, grooming, meal preparation, housekeeping, and laundry. R2's Medication Administration Records (MAR) for August 14, 2025, through September 21, 2025, indicated the following: - Flonase 27.5 micrograms (mcg) was declined due to medication not available 34 times out of the 39 days included on the MAR; and - Simply Saline nasal spray was declined due to medication not available 39 times out of the 39 days included on the MAR. On September 23, 2025, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated they have not followed up with R2's provider to advise R2 has not been receiving these medications due to insurance not covering and R2 not wanting to pay out of pocket for them. Registered nurse (RN)-C stated they thought family might provide these medications for R2 but have not documented in R2's records any notes to indicate any follow-up on the missed medications for R2 had been completed. The licensee's Medication Documentation policy dated May 24, 2024, indicated if the administration of one or more medication's was not completed, staff will document the following: - the reason why the medication was not administered;	01760		

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01760	Continued From page 16 - follow up procedures to meet the resident's needs in compliance with the medication management plan; appropriate notification to RN Supervisor or other persons as instructed regarding missed doses; and - medication error report, if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date for two of three residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01890		

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01890	Continued From page 17 The findings include: On September 23, 2025, at 9:05 a.m., the surveyor observed registered nurse (RN)-C administer medications to R3, which included a Lantus insulin injection. The surveyor observed the Lantus insulin pen which did not indicate a date in which the insulin pen was opened. RN-C stated they normally date the insulin pens when they are opened but he was unsure about this pen. On September 23, 2025, at 9:35 a.m., RN-D stated she thinks the Lantus insulin pen was opened the same day R3 was emergently sent to the hospital, and the open date was missed being added to the pen. On September 23, 2025, at 10:00 a.m., the surveyor observed the medication cabinets for the residents of the facility with RN-C and found an opened Advair inhaler for R2 that did not include an open date. RN-C acknowledged the inhaler was missing an open date and it might have come with R2 upon admission. The manufacturer's instructions for the Lantus insulin pen dated August 2022, indicated after 28 days, throw your opened insulin glargine pen away even if it still has insulin in it. The manufacturer's instructions for Advair inhaler dated January 2019, indicated safely throw away the inhaler in the trash one month after you open the foil pouch or when the counter reads zero, whichever comes first. The licensee's Storage/Control of Medications	01890		

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01890	Continued From page 18 policy dated May 24, 2024, indicated the licensed nurse is responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with hospital-style bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 22, 2025, at 2:00 p.m., the	02310		

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02310	Continued From page 19 surveyor observed R2's bilateral bed rails attached to the hospital bed. R2 stated the nurse discussed the bed rails with him at admission, he wanted them on his bed to assist with repositioning in bed, and he signed some paperwork about the bed rail. R2 was admitted to the licensee on August 13, 2025, with diagnoses of cerebral infarction (stroke) and essential hypertension. R2's signed Service Plan dated August 14, 2025, indicated R2 received services to include medication administration, dressing, grooming, meal preparation, housekeeping, and laundry. R2's bed rail assessment dated August 13, 2025, lacked documented bed rail measurements for three of the four required measurements. On September 23, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated she did not realize the measurements two-four were applicable for the hospital bed rail and missed adding them because she did not think they applied. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated December 11, 2017, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."	02310		

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02310	Continued From page 20 Additionally, per FDA recommendations, the need for bed rails must be assessed on a "frequent, regular basis." At a minimum this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to	02310		

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02310	Continued From page 21 interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rail Use policy dated May 24, 2024, indicated documentation regarding the side rails will include the following: - the measurements; - installation; - condition; - results of the physical inspection of the side rails and mattress for areas of entrapment and stability; and - any other information to mitigate safety risks. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

KAYO HEALTH CARE CENTER LLC
5941 6TH STREET NORTHEAST
Fridley, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 40979

Risk:
License:
Expires on:
CFPM: ZERITU WOYESA MUTAL
CFPM #: 55186; Exp: 8/11/2027

Inspection Info

Report Number: F1029251210
Inspection Type: Full - Single
Date: 9/23/2025 Time: 12:15:40 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

New Order: 2-300 Personal Cleanliness

2-301.12C *Priority Level: Priority 3 CFP#: 8*

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.
COMMENT: STAFF TURNED FAUCET OFF WITH BARE HANDS AFTER HANDWASHING. CORRECT HANDWASHING STEPS REVIEWED DURING INSPECTION.

Comply By: 9/23/2025 Originally Issued On: 9/23/2025

New Order: 4-200 Equipment Design and Construction

4-201.11GMN *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: PREPARED HEATED TOMATO SAUCE WITH MULTIPLE INGREDIENTS HELD BEYOND SAME-DAY SERVICE. DISCONTINUE PRACTICE OR PROVIDE EQUIPMENT CLASSIFIED FOR SANITATION BY AND ANSI ACCREDITED CERTIFYING BODY (I.E., COMMERCIAL EQUIPMENT).

Comply By: 9/23/2025 Originally Issued On: 9/23/2025

Food & Beverage General Comment

Food and beverage inspection of establishment conducted as part an HRD survey. Kitchen residential in nature with high heat sanitizing dishwasher for which thermal stickers are used to verify sanitizing temperatures. Identified issues reviewed with staff.

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

I acknowledge receipt of the Metro District Office inspection report number F1029251210 from 9/23/2025

Trevor McCliment

ZEE MUTAL
PERSON IN CHARGE

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

KAYO HEALTH CARE CENTER LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1029251210
Inspection Type: Full
Date: 9/23/2025
Time: 12:15:40 PM

New Record: **Product/Item/Unit:** SLICED DELI MEAT**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 35 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** CREAMER; **Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 40 Degrees F.
Comment:
Violation Issued?: No