



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 4, 2026

Licensee
Joy Living Inc
430 Niagara Lane North
Plymouth, MN 55447

RE: Project Number(s) SL35819016

Dear Licensee:

On May 26, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 25, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

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

KKM



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 24, 2026

Licensee
Joy Living Inc
430 Niagara Lane North
Plymouth, MN 55447

RE: Project Number(s) SL35819016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 25, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

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

pursuant to this survey:

St - 0 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$1,000.00
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00
St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - \$1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

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

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER JOY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 430 NIAGARA LANE NORTH PLYMOUTH, MN 55447		
(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: SL35819016-0 On February 23, 2026, through February 25, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents all of whom received services under the Assisted Living Facility license. An immediate correction order was identified on February 23, 2026, issued for SL35819016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on February 24, 2026, issued for SL35819016-0, tag	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 identification 0495. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000			
0 330 SS=I	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide truthful and accurate information when the licensee attested verbally that resident room 5 was not occupied by a resident and was only used for storage and office. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 330			

Minnesota Department of Health

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0 330	Continued From page 2 The findings include: During a routine survey conducted on March 20, 2024, licensed assisted living director (LALD)-D was on site and present for the physical environment tour. LALD-D was identified in the March 20, 2024, survey orders using the identifier, director (D)-A. On March 20, 2024, the egress window in unoccupied resident room 5 was identified as undersized. The facility was tagged using the 0800 tag identification number for failure to update their facility exit diagram to change the labeling on resident room 5 to office/training room to accurately display the use of the room after a capacity decrease was approved. Prior to the March 20, 2024, survey, the licensee submitted to the Minnesota Department of Health (MDH) a request for a capacity decrease, dated December 18, 2023. In the capacity decrease request, the licensee stated: "This house has only 5 rooms. We will use the 5th room as office/storage/training. Please reduce our capacity from 5 to 4". The capacity decrease from 5 residents to 4 was approved by MDH on December 21, 2023. On February 23, 2026, at approximately 12:50 p.m., during the facility tour, the surveyor observed an unlabeled door on the second floor of the facility. The numbering of the other resident rooms in the facility was 1, 2, 3, and 4. Survey staff asked LALD-D what the unlabeled room was used for, and LALD-D stated it was for storage and office use. The contents of the room were consistent with a resident room and not with those of an office and storage area. There was a bed with bedding,	0 330			

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0 330	Continued From page 3 clothes, personal effects, and personal care/toiletry items. LALD-D stated again to the surveyor that the room was used for office and storage. On February 23, 2026, at 9:23 a.m., during the facility tour, unlicensed personnel (ULP)-B stated room number three was an unoccupied room, and the unlabeled room, referred to by ULP-B as room five, was occupied by R4. On February 23, 2026, at 12:55 p.m., R3 stated no resident occupied room three, and R4 occupied room five. On February 23, 2026, at 12:56 p.m., the surveyor visually confirmed that the room labeled resident room 3 appeared unoccupied. There was a bed with bedding in the room. There were no personal effects, clothes, or personal care/toiletry items observed in the room or in the closet. TIME OF PERIOD OF CORRECTION: Two (2) days	0 330			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30	0 340			

Minnesota Department of Health

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0 340	Continued From page 4 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation of actions taken to comply with the correction orders from a survey completed March 20, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 18, 2024, the licensee received results from the previous survey concluded on March 20,	0 340			

Minnesota Department of Health

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0 340	Continued From page 5 2024. The longest time period for correction (the time frame by which the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was May 9, 2024. The licensee's correction orders included, in part, tag identifiers 0640 related to 1446.42 Subd. 7. Posting information for reporting suspected crime and maltreatment, 0660 related to 1446.42 Subd. 9. Tuberculosis prevention and control., and 0680 related to 144G.42 Subd. 10. Disaster planning and emergency preparedness plan. The licensee's undated Plan of Correction (POC) indicated the following: - staff and licensed assisted living director (LALD) have posted information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC); - all staff were required to have proof of freedom from tuberculosis (TB) at hire. The test results must be completed within 90 days of hire or at hire and include a TB test and symptom screen. The LALD would verify all newly hired staff have completed TB requirement upon hire.; and - LALD would check quarterly to verify the emergency preparedness plan (EPP) was posted and current. On February 24, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-C stated they had not had a part in the licensee's TB program since the start of their employment because employees of the licensee were hired prior to their start of employment. On February 24, 2026, at 1:33 p.m., during an interview with LALD-D, CNS-C, and housing manager (HM)-A, LALD-D stated there were two postings in the facility that contained the MAARC	0 340			

Minnesota Department of Health

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0 340	Continued From page 6 number. The surveyor requested to see where the postings were located. LALD-D stated they should be on the board in the living room. HM-A then stated they took the MAARC postings down last week to update the information on it. HM-A stated they did not have enough time to put up the postings again. LALD-D stated they did not know the postings were removed. On February 24, 2026, at 1:38 p.m., during interview with CNS-C, LALD-D, and HM-A, HM-A stated new employees were assigned an infection control module that contained education related to TB in EduCare (training software program), completed TB screening questions, and were tested for TB. HM-A stated they reviewed the TB results for staff, or the nurse reviewed the results. CNS-C stated when the licensee reviewed TB results they look to see if they are negative or positive. HM-A stated they did not have another Mantoux result for unlicensed personnel (ULP)-B. HM-A stated they did know why ULP-B's record lacked a second step Mantoux. On February 24, 2026, at 1:42 p.m., during an interview with CNS-C, LALD-D, and HM-A, HM-A and LALD-D both verified the EPP lacked information related to staffing shortages. HM-A stated the missing resident plan was reviewed once or twice per year. LALD-D stated they did not know how often the missing resident plan was reviewed. LALD-D continued to look through the EPP and stated the missing resident review was reviewed quarterly. LALD-D stated they did not have documentation of the missing resident plan being reviewed. LALD-D stated they did not address their current resident population. LALD-D stated the EPP did not have specific substance needs for staff and residents. LALD-D stated they had a primary place for the licensee to evacuate	0 340			

Minnesota Department of Health

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0 340	Continued From page 7 to, and they would provide the agreement between the two facilities to the surveyor. The surveyor did not receive the agreement prior to the completion of the survey. In addition, the licensee said they have another location they would evacuate to in case of an emergency however, it was not written in the EPP nor did they have an agreement with the other location signed. HM-A stated the licensee conducted a power outage drill. The surveyor requested to see documentation of the drill. The surveyor did not receive documentation of the drill prior to the exit of the survey. Per the POC the EPP would be reviewed quarterly. Per documentation of the EPP the document was not reviewed on a quarterly basis. The POC was not being followed. Per POC the LALD was to verify whether all new staff completed requirements for TB. Per the interview noted above, HM-A managed the TB process for new hires. The POC was not being followed. During the survey initiated on February 25, 2026, and exited on January 21, 2026, areas of deficient practice related to tags 0640, 0660, and 0680 were identified and the correction orders were re-issued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

Minnesota Department of Health

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0 420	Continued From page 8 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient housing and service-related management, control, and operation of the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living licensure issued on July 1, 2025, with an expiration date of June 1, 2026. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page three of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota	0 420			

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0 420	Continued From page 9 Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and belief, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page three was electronically signed by the owner (O)-E on May 14, 2025. As a result of this survey, the following orders were issued under tag identification numbers 0330, 0340, 0470, 0480, 0495, 0550, 0630, 0640, 0660, 0680, 0775, 0780, 0790, 0800, 0810, 0910, 1060, 1620, 1730, and 1890 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 470	Continued From page 10 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470			

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0 470	Continued From page 11 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 23, 2026, at 9:23 a.m., during a facility tour, the surveyor observed a board which included multiple postings in the living room. The board included a document titled Monthly Schedule Plan dated January 2026, which indicated from 8:00 a.m. to 4:00 p.m., 4:00 p.m. to 10:00 p.m., and 10:00 p.m. to 8:00 a.m., one staff member was scheduled to work at the facility. There was a second staff member scheduled to be at the facility from 11:00 p.m. to 7:00 a.m. In addition, the plan indicated the following: - the director was on-call on Sundays, Mondays, Fridays, and Saturday. The director was scheduled Tuesday, Wednesday, and Thursday; - the registered nurse (RN) was on-call on Sundays, Mondays, Thursdays, Fridays, and Saturdays. The RN was scheduled on Tuesdays and Wednesdays; and - the "24/7 Manager/RN" was on-call daily Sunday through Saturday. The document included seven days of information indicated by the days of the week listed at the top of the document. The document was not dated with the dates that Sunday through Saturday corresponded to. The document did not meet the requirements of a daily staff schedule. On February 23, 2026, at 10:43 a.m., clinical nurse supervisor (CNS)-C stated the document listed above was the daily staffing schedule the licensee posted. CNS-C stated the licensee recently hired a consultant to assist the licensee	0 470			

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0 470	Continued From page 12 and the consultant recommended a change to the licensee's staffing plan. CNS-C stated they misunderstood the consultant on what was needed for the staffing schedule. The surveyor inquired why the document listed above had no dates. CNS-C stated, "Sorry, I think that was my fault." The licensee's Staffing policy dated August 1, 2021, indicated a daily staffing schedule was prepared by the CNS and addressed the following: - unlicensed personnel (ULP) work schedules for each ULP showing all work shifts with day and hours worked; - the ULP resident assignments or work locations. In addition, the schedule was posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius	0 480			

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0 480	Continued From page 13 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, 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	0 480			

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0 480	Continued From page 14 provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 23, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week.	0 495			

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0 495	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living licensure valid through June 30, 2026. The licensee's current census was four residents. One resident was hospitalized at the time of the survey. R1 R1 was admitted to the licensee on June 8, 2022, and began receiving assisted living services. R1's diagnoses included gout, anxiety, bipolar disorder, depression, and mood disorder. R1's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R1 received assistance with appointments, bathing reminders, dressing, grooming, laundry, behavior management for agitation, anxiety, and verbal aggression, meals, medication administration, vital sign monitoring, shopping, and socialization.	0 495			

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0 495	Continued From page 16 R1's Resident Profile dated July 24, 2025, indicated R1 received the following medications: - cariparazine (an atypical antipsychotic) 6 milligrams (mg) at bedtime for agitation; - divalproex sodium (an anticonvulsant) 1500 mg at bedtime for mood disorder; - olanzapine (an atypical antipsychotic) 2.5 mg at bedtime for anxiety; and - olanzapine 5 mg as needed (PRN) one time per day for agitation. R2 R2 was admitted to the licensee on December 20, 2020, and began receiving assisted living services. R2's diagnoses included schizoaffective disorder (mental health condition that combines symptoms of schizophrenia and mood disorder affecting thoughts, emotions, and behavior), and gastroesophageal reflux disease (GERD). R2's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R2 received assistance with bathing reminders, dressing, grooming, behavior management for agitation, verbal aggression, and wandering, medication administration, oxygen saturation monitoring, temperature monitoring, and safety checks. R2's Resident Profile dated February 23, 2026, indicated R2 received the following medications: - hydroxyzine (an antihistamine) 25 mg at bedtime for anxiety; - lurasidone hydrochloride (an antipsychotic) 120 mg at bedtime for schizophrenia; and - topiramate (antiepileptic) 50 mg at 8:00 p.m., for mood stabilization and seizure.	0 495			

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0 495	Continued From page 17 R3 R3 was admitted to the licensee on February 4, 2022, and began receiving assisted living services. R3's diagnoses included psychosis, anxiety, asthma, bipolar disorder, depression, and high blood pressure. R3's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R3 received assistance with bathing reminders, dressing, grooming, behavior management for agitation, anxiety, repetitiveness, and verbal aggression, medication administration, vital sign monitoring, and safety checks. R3's Resident Profile dated February 23, 2025, indicated R3 received the following medications: - aripiprazole (an antipsychotic) 10 mg at bedtime for psychosis; - duloxetine (a serotonin-norepinephrine reuptake inhibitor) 20 mg at bedtime for depression - Risperdal (atypical antipsychotic) 2 mg at bedtime; and - Olanzapine 5 mg PRN at night for agitation or sleep. R4 R4 was admitted to the licensee on July 3, 2024, and began receiving assisted living services. R4's diagnoses included depression, anxiety, and schizophrenia (mental disorder that affects how a person thinks, feels and behaves, often leading to hallucinations, delusions, and disorganized thinking.) R4's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R4	0 495			

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0 495	Continued From page 18 received assistance with appointments, bathing reminders, dressing, grooming, laundry, behavior management for agitation, anxiety, and verbal aggression, meals, medication administration, vital sign monitoring, safety checks, shopping, and socialization. R4's Resident Profile dated February 23, 2025, indicated R4 received the following medications: - aripiprazole 10 mg at 10:00 a.m., for atypical antipsychotic medication; - bupropion extended release (atypical antidepressant) 150 mg at 10:00 a.m., for anxiety and depression; and - Olanzapine 5 mg PRN for agitation. On February 23, 2026, at 9:15 a.m., unlicensed personnel (ULP)-B stated R4 was admitted to the hospital four days ago. The licensee's undated Employee List indicated the licensee had one registered nurse who was employed with the facility. The licensee's Staffing Plan dated August 1, 2021, [sic] indicated from 7:00 a.m. to 3:30 p.m., 3:00 p.m. to 11:30 p.m., and 11:00 p.m. to 7:30 a.m. one staff member would be present at the facility. The director was available by appointment on Saturdays and Sundays and was at the facility on Wednesday from 1:00 p.m. to 5:00 p.m. and Thursday and Fridays from 8:00 a.m. to 12:00 p.m. In addition, there was a 24/7 manager and registered nurse (RN) on call daily. The licensee's Monthly Schedule Plan dated January 26, 2026, indicated from 8:00 a.m. to 4:00 p.m., 4:00 p.m. to 10:00 p.m., and 10:00 p.m. to 8:00 a.m., one staff member was scheduled to work at the facility. There was a	0 495			

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0 495	Continued From page 19 second staff member scheduled to be at the facility from 11:00 p.m. to 7:00 a.m. In addition, the schedule plan indicated the following: - the director was on-call on Sundays, Mondays, Fridays, and Saturday. The director was scheduled Tuesday, Wednesday, and Thursday; - the RN was on-call on Sundays, Mondays, Thursdays, Fridays, and Saturdays. The RN was scheduled on Tuesdays and Wednesdays; and - the "24/7 Manager/RN" was on call daily Sunday through Saturday. On February 23, 2026, at approximately 10:00 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated they did not know if the licensee employed other RNs. CNS-C stated they worked part time at a hospital as a psychiatric nurse, and they were providing direct patient care at the hospital. CNS-C stated if staff needed to contact an on-call nurse they would text, call, or use the Residex (a documenting software program) messaging system. CNS-C stated they were on-call most of the time. CNS-C stated they came to the facility one time per week but could be reached by phone as well. CNS-C stated if they received a phone call while they were at their other place of employment, they would "step out" and provide feedback. The surveyor inquired what they would do if they were providing patient care at the hospital and received a phone call. CNS-C stated they would finish the care with the patient and then contact the staff at the facility. CNS-C stated normally staff called when they were preparing medication or charting so they were able to answer. The surveyor inquired if they would pick up the phone if they were in a patient's room. CNS-C stated they would not answer the phone because it would invade patient privacy, "I would have to step out." The surveyor inquired if their other place of	0 495			

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0 495	Continued From page 20 employment would have any concerns with them stepping out of a room to answer the phone from another place of employment. CNS-C stated they did not feel comfortable answering the question because it had never happened to them before. On February 23, 2026, at 11:01 a.m., housing manager (HM)-B stated they assisted in managing the company and oversaw day-to-day operation at the facility. On February 23, 2026, at 11:04 a.m., HM-B stated they were familiar with the assisted living statues and requirements. On February 23, 2026, at 11:09 a.m., HM-B stated CNS-C was the only RN who was employed by the licensee. HM-B stated the licensee was looking into hiring an additional RN in case CNS-C was unavailable. HM-B stated CNS-C had been the only RN at the facility since July 2025, and they had not had any issues getting ahold of CNS-C. HM-B stated the licensee was having difficulty hiring an additional nurse because no one wanted to just work on-call. On February 23, 2026, at 11:16 a.m., ULP-B stated they have not had any issues getting ahold of CNS-C. On February 24, 2026, at 9:46 a.m., CNS-C stated they worked rotating shifts every other weekend plus two overnight shifts per pay period at the hospital. CNS-C stated 24/7 Manager/RN on the staffing plan meant they were available, and HM-B was also available for phone calls. The surveyor inquired if it was just one of them at a time as the staffing plan indicated one staff member would cover. CNS-C stated that it may have been written on the staffing plan that way by	0 495			

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0 495	Continued From page 21 mistake. CNS-C stated they worked at the facility once per week and could come to the facility if needed. CNS-C stated the days they come in may change based on the need. The surveyor inquired why the staffing plan indicated the RN would be at the facility two days a week. CNS-C stated that it was not "part of the plan" they were to come to the facility one day a week however, if they were needed more, they may have to come a additional time but it would not be scheduled. On February 24, 2026, at 10:32 a.m., during an interview with licensed assisted living director (LALD)-D and HM-B, LALD-D stated they were aware CNS-C had another job. LALD-D stated CNS-C was at the facility twice per week but has been available via phone right away when called. HM-B then stated CNS-C reduced their hours to one day per week at the facility. LALD-D stated that even though CNS-C had another job, they went beyond their job description. LALD-D stated in the event of emergency if the nurse was not available, staff could call 911. LALD-D stated they misunderstood the statute and believed the nurse needed to be available for training, medication, and questions from ULP. LALD-D stated, "I did not think she had to be available 24 hours a day." The licensee's Staffing policy dated August 1, 2021, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet resident's needs at all times including reasonably foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			

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0 550	Continued From page 22	0 550			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place information about the licensee's grievance procedure which would include the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances. In addition, the licensee failed to post contact information for the Office of Ombudsman for Long Term Care (OOLTC) and Office of Mental Health and Developmental Disabilities (OOMHDD). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 550			

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0 550	Continued From page 23 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 23, 2026, at 9:23 a.m., during a facility tour, the surveyor did not observe a posting of the licensee's grievance procedure or contact information for OOLTC and OOMHDD. On February 24, 2026, 1:33 p.m., during an interview with licensed assisted living director (LALD)-D, clinical nurse supervisor (CNS)-C, and housing manager (HM)-A, LALD-D stated there were two postings in the facility that contained the grievance notice. The surveyor requested to see where the postings were located. LALD-D stated they should be on the board in the living room. HM-A then stated they took the grievance postings down last week to update the information on it. HM-A stated they did not have enough time to put up the postings again. LALD-D stated they did not know the postings were removed. The licensee's Grievance policy dated August 1, 2021, indicated a copy of the grievance procedure was conspicuously posted in the residence with the following information: - name, phone number, and email contact information for the individuals who are responsible for handling resident complaints; - contact information for the state and any regional OOTLC; - contact information for OOMHDD; and - contact information for Minnesota Adult Abuse	0 550			

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0 550	Continued From page 24 Reporting Center (MAARC). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 630			

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0 630	Continued From page 25 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee on June 8, 2022, and began receiving assisted living services. R1's diagnoses included gout, anxiety, bipolar disorder, depression, and mood disorder. R1's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R1 received assistance with appointments, bathing reminders, dressing, grooming, laundry, behavior management for agitation, anxiety, and verbal aggression, meals, medication administration, vital sign monitoring, shopping, and socialization. R1's IAPP dated December 22, 2025, included R1 was at risk to be abused and statements of specific measure to be taken to reduce the risk of R1 being abused. In addition, the IAPP indicated R1 experienced agitation, physical aggression, repetitive behaviors, verbal aggression, impulsiveness, and psychotic behaviors. R1's IAPP lacked an individualized review or assessment of R1's risk of abusing other vulnerable adults. R2 R2 was admitted to the licensee on December 20, 2020, and began receiving assisted living services. R2's diagnoses included schizoaffective disorder (mental health condition that combines symptoms of schizophrenia and mood disorder affecting thoughts, emotions, and behavior), and	0 630			

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0 630	Continued From page 26 gastroesophageal reflux disease (GERD). R2's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R2 received assistance with bathing reminders, dressing, grooming, behavior management for agitation, verbal aggression, and wandering, medication administration, oxygen saturation monitoring, temperature monitoring, and safety checks. R2's IAPP dated January 14, 2026, indicated R2 experienced agitation, verbal aggression, psychosis, and disorientation. R2's IAPP lacked the following required content: - individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; - individualized review or assessment of the person's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On February 24, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-C stated nursing assessments contained questions related to vulnerability and once an assessment was completed, Residex (a documenting software program) would generate an IAPP. CNS-C stated they missed addressing the required content listed above in the assessment. CNS-C stated they had been employed with the licensee for six months and they believed they were following previous nursing assessments which is why the content was not addressed. CNS-C verified R1 and R2's IAPP lacked the required content listed above. CNS-C stated both R1 and R2 were vulnerable adults.	0 630			

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0 630	Continued From page 27 The licensee's Vulnerable Adult policy dated August 1, 2021, indicated the licensee's employees were required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. In addition, the individual abuse prevention plan shall be established for each vulnerable adult for whom assisted living services were provided. The plan shall contain an individualized assessment of the resident's susceptibility to abuse by other individual, including other vulnerable adults, the risk of abusing other vulnerable adults, and statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640			

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0 640	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 23, 2026, at 9:23 a.m., during a facility tour, the surveyor did not observe information or a reporting number for MAARC posted in the common areas of the facility. On February 24, 2026, 1:33 p.m., during an interview with licensed assisted living director (LALD)-D, clinical nurse supervisor (CNS)-C, and housing manager (HM)-A, LALD-D stated there were two postings in the facility that contained the MAARC number. The surveyor requested to see where the postings were located. LALD-D stated they should be on the board in the living room. HM-A stated they took the MAARC postings down last week to update the information on them. HM-A stated they did not have enough time to put up the postings again. LALD-D stated they did not know the postings were removed.	0 640			

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0 640	Continued From page 29 The licensee's Vulnerable Adult policy dated August 1, 2021, indicated contact information for MAARC shall be posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening	0 660			

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0 660	Continued From page 30 such as a blood test for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The licensee's TB facility risk assessment completed January 4, 2026, indicated the facility's TB risk level was low. ULP-B was hired on January 21, 2025, to provide assisted living services to residents. On February 23, 2026, at 9:08 a.m., the surveyor observed ULP-B administer oral medication to R1. ULP-B's personnel record included a Baseline TB Screening Tool for Healthcare Workers (HCWs) completed on January 17, 2025, and a first-step Mantoux read on January 21, 2025, that had a negative result. ULP-B's personnel file lacked a second-step Mantoux. On February 24, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-C stated they had not had a part in the licensee's TB program since the start of their employment because employees of the licensee were hired prior to their start of employment.	0 660			

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0 660	Continued From page 31 On February 24, 2026, at 1:38 p.m., during an interview with CNS-C, licensed assisted living director (LALD)-D, and housing manager (HM)-A, HM-A stated new staff were assigned an infection control module that contained education related to TB in EduCare (training software program), staff completed TB screening questions, and were tested for TB. HM-A stated they or the nurse reviewed the results. CNS-C stated when the licensee reviewed TB results, they looked to see if they were negative or positive. HM-A stated they did not have another Mantoux result for ULP-B. HM-A stated they did know why ULP-B's record lacked a second step Mantoux. The CDC's Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 15, 2023, indicated all United States health care personnel should be screened for TB upon hire. TB screening included a baseline individual TB risk assessment, TB symptom evaluation, a TB test, and additional evaluation for TB disease as needed. The Minnesota Department of Health's Regulations for Tuberculosis Control in Minnesota Health Care Settings guide dated July 2013 recommended if the first step TST was negative, a second step TST should be conducted in one to three weeks. The licensee's Tuberculosis Screening / Prevention policy dated August 1, 2021, indicated baseline testing was completed on hire for all direct care providers and anyone who visits residents including volunteers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

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0 660	Continued From page 32 (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680			

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0 680	Continued From page 33 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP titled Emergency Preparedness Manual reviewed last on December 6, 2025, lacked evidence of the following required content: - strategies for addressing facility and community-based risks that included staffing shortages and back-up plans; - quarterly review of the missing resident plan; - emergency plan (EP) population; - substance needs for staff and residents; - alternative location in case of an evacuation; - arrangements with other facilities; and - emergency prep testing. On February 24, 2026, at 1:42 p.m., during an interview with clinical nurse supervisor (CNS)-C, licensed assisted living director (LALD)-D, and housing manager (HM)-A, HM-A and LALD-D both verified the EPP lacked information related to staffing shortages. HM-A stated the missing resident plan was reviewed once or twice per year. LALD-D stated they did not know how often the missing resident plan was reviewed. LALD-D continued to look through the EPP and stated the missing resident review was reviewed quarterly, but they did not have documentation of the missing resident plan being reviewed. LALD-D stated they did not address their current resident	0 680			

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0 680	Continued From page 34 population. LALD-D stated the EPP did not have specific substance needs for staff and residents. LALD-D stated they had a primary place for the licensee to evacuate to, and they would provide the agreement between the two facilities for the surveyor. The surveyor did not receive the agreement prior to the completion of the survey. In addition, the licensee said they have another location they would evacuate to in case of an emergency however, it was not written in the EPP, nor did they have an agreement with the other location signed. HM-A stated the licensee conducted a power outage drill. The surveyor requested to see documentation of the drill. The surveyor did not receive documentation of the drill prior to the exit of the survey. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=G	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775			

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0 775	Continued From page 35 failed to provide egress windows in compliance with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at 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 February 23, 2026, the surveyor toured the facility with licensed assisted living director (LALD)-D. During the tour, survey staff asked LALD-D to open the windows in the resident rooms for measurement. The noncompliant measurements were as follows: Resident room 5: The window measured 26 inches clear width, 19 ½ inches clear height, and 507 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On February 23, 2026, at approximately 12:50 p.m., during the facility tour LALD-D stated that resident room 5 was not occupied and that it was used for office and storage. The surveyor observed a bed, clothing, and other personal belongings inside room 5. The room	0 775			

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0 775	Continued From page 36 was not set up as an office or storage space. On February 23, 2026, at 9:23 a.m., during a facility tour, unlicensed personnel (ULP)-B stated room number three was an unoccupied room and room number five was occupied by resident (R4). On February 23, 2026, at 12:55 p.m., resident (R3) stated no resident occupied room three and R4 occupied room five. TIME PERIOD FOR CORRECTION: Immediate Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 02/23/2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780			

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0 780	Continued From page 37 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/23/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER JOY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 430 NIAGARA LANE NORTH PLYMOUTH, MN 55447		
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0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/23/2026, for the specific violations related the physical environment under Minnesota Statute	0 790			

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0 790	Continued From page 39 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800			

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0 800	Continued From page 40 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/23/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill	0 810			

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0 810	Continued From page 41 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/23/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous	0 910			

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0 910	Continued From page 42 place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had a Health Facility identification number (HFID#) of 35819. R1 R1 admitted to the licensee on June 8, 2022, and began receiving assisted living services. R1's Assisted Living Contract signed July 24, 2025, indicated the assisted living HFID# was 403133. R1's contract did not accurately identify	0 910			

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0 910	Continued From page 43 the HFID# of the licensee. R2 R2 admitted to the licensee on December 20, 2020, and began receiving assisted living services. R2's Assisted Living Contract signed July 24, 2025, indicated the assisted living HFID# was 403133. R2's contract did not accurately identify the HFID# of the licensee. R3 R3 admitted to the licensee on February 4, 2022, and began receiving assisted living services. R3's Assisted Living Contract signed July 24, 2025, indicated the assisted living HFID# was 34608. R3's contract did not accurately identify the HFID# of the licensee. On February 24, 2026, at 1:55 p.m., licensed assisted living director (LALD)-D stated the licensee received the contract template from a previously employed nurse and they forgot to change the HFID# on the templated contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
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.	01060			

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01060	Continued From page 44 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 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:	01060			

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01060	Continued From page 45 Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R4). 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: R4 was admitted to the licensee on July 3, 2024, and began receiving assisted living services. R4's diagnoses included depression, anxiety, and schizophrenia (mental disorder that affects how a person thinks, feels and behaves, often leading to hallucinations, delusions, and disorganized thinking.) R4's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R4 received assistance with appointments, bathing reminders, dressing, grooming, laundry, behavior management for agitation, anxiety, and verbal aggression, meals, medication administration, vital sign monitoring, safety checks, shopping, and socialization.	01060			

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01060	Continued From page 46 R4's progress note dated February 18, 2026, indicated R4 was admitted to the hospital for inpatient psychiatric care. R4's record included an emergency relocation notice that was completed on February 23, 2026, after the surveyor requested the document. R4's record lacked previous evidence the licensee provided the resident or resident's representative a written emergency relocation notice. R4's record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On February 23, 2026, at 9:15 a.m., unlicensed personnel (ULP)-B stated R4 was admitted to the hospital four days ago and had not returned. On February 24, 2026, at 10:43 a.m., licensed assisted living director (LALD)-D stated it was the licensee's first emergency relocation, and they were not familiar with the process. LALD-D stated the nurse told them about the emergency relocation notice and they began to work on it, which was why the emergency relocation notice was created during the survey. LALD-D stated the emergency relocation notice had not been sent to OOLTC however, they would send it. LALD-D stated it was something new they were learning about. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, 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;	01060			

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01060	Continued From page 47 - if the resident receives home and community-based services, the resident's case manager; and - if the resident has been relocated and not returned to the licensee within four days, OOTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days.	01620			

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01620	Continued From page 48 (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01620			

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01620	Continued From page 49 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee on December 20, 2020, and began receiving assisted living services. R2's diagnoses included schizoaffective disorder (mental health condition that combines symptoms of schizophrenia and mood disorder affecting thoughts, emotions, and behavior), and gastroesophageal reflux disease (GERD). R2's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R2 received assistance with bathing reminders, dressing, grooming, behavior management for agitation, verbal aggression, and wandering, medication administration, oxygen saturation monitoring, temperature monitoring, and safety checks. R2's record included ongoing assessments dated October 14, 2025, and January 14, 2026, indicating 93 days passed between the October and January assessments. R3 R3 was admitted to the licensee on February 4, 2022, and began receiving assisted living services. R3's diagnoses included psychosis, anxiety, asthma, bipolar disorder, depression, and high blood pressure. R3's Service Plan (Waiver) - Addendum to	01620			

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01620	Continued From page 50 Contract signed July 24, 2025, indicated R3 received assistance with bathing reminders, dressing, grooming, behavior management for agitation, anxiety, repetitiveness, and verbal aggression, medication administration, vital sign monitoring, and safety checks. R3's record included ongoing assessments dated September 30, 2025, and January 8, 2026, indicating 101 days passed between the September and January assessments. On February 24, 2026, at 1:09 p.m., clinical nurse supervisor (CNS)-C stated ongoing assessments were completed every 90 days. CNS-C stated they miscalculated R2 and R3's ongoing assessments. CNS-C stated they completed the previous assessment early and they believed the ongoing 90-day assessments were calculated every 90 days from the original assessment not the most recent assessment. CNS-C stated it was "my misunderstanding" of how 90-day assessments needed to be completed. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident assessments must be conducted by a registered nurse (RN) and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730			

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01730	Continued From page 51 management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER JOY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 430 NIAGARA LANE NORTH PLYMOUTH, MN 55447		
(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
01730	Continued From page 52 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on June 8, 2022, and began receiving assisted living services. R1's diagnoses included gout, anxiety, bipolar disorder, depression, and mood disorder. R1's Service Plan (Waiver) - Addendum to Contract signed July 24, 2025, indicated R1 received assistance with appointments, bathing reminders, dressing, grooming, laundry, behavior management for agitation, anxiety, and verbal aggression, meals, medication administration, vital sign monitoring, shopping, and socialization. On February 23, 2026, at 9:08 a.m., the surveyor observed unlicensed personnel (ULP)-B	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER JOY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 430 NIAGARA LANE NORTH PLYMOUTH, MN 55447		
(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
01730	Continued From page 53 administer oral medication to R1. R1's ongoing assessment dated December 22, 2025, indicated the following: - staff would administer medication to R1; - "Specific resident instructions relating to the administration, monitoring, and documentation of medications, specify: No"; - R1 took medications whole with water; - registered nurse (RN) was responsible for monitoring and reordering medications; - R1's medications were kept in a locked unit staff could only access; - ULP were allowed to administer eye drops, inhaler, oral, topical, transdermal medications to R1; - ULP could contact the nurse by phone if concerns arose with medication. R1's Med Admin Summary - Month dated February 2026 included the following medication orders: - albuterol inhale one to two puffs by mouth every six hours as needed (PRN); and - zolpidem take one to two tablets by mouth at night as needed. The medication administration record (MAR) lacked when the ULP should administer one puff vs two puffs of albuterol to R1. In addition, the MAR lacked when ULP should administer one tablet verses two tablets of zolpidem and lacked a milligram (mg) dosage for the medication. R1's medication management plan comprised of multiple documents lacked specific written instructions for R1 medication administration. On February 24, 2026, at 2:07 p.m., the surveyor had clinical nurse supervisor (CNS)-C open Residex (a documenting software program) to	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER JOY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 430 NIAGARA LANE NORTH PLYMOUTH, MN 55447		
(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
01730	Continued From page 54 observe additional hidden instructions for R1's albuterol inhaler and zolpidem. The surveyor observed the hidden instructions and observed the instructions lacked detail of how ULP should administer the two medications listed above. CNS-C stated they did not have additional details for how ULP should administer the two medications. CNS-C stated ULP should administer one puff of albuterol if R1 experienced tightness to their chest and two puffs if R1 experienced severe difficulty with breathing. CNS-C stated zolpidem was used for sleep. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated a written medication management plan would include: - a statement describing the medication management services to be provided; - a description of the storage of medications based on the resident assessment; - documentation of procedures; - procedures for medication reconciliation; - identification of person responsible for monitoring medication supplies and ensuring refills are ordered timely; - description of medication management tasks to be delegated to ULP; - plans for staff notifying the licensed health professional when a problem arose with medication management services; and - any resident specific requirements related to documenting medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER JOY LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 430 NIAGARA LANE NORTH PLYMOUTH, MN 55447			
(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
01890	Continued From page 55	01890			
01890 SS=D	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 discard expired medication for one of four residents (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). The findings include: On February 23, 2026, at 9:15 a.m., the surveyor observed R2's medication bin in the locked medication cabinet and observed four pieces of nicotine polacrilex gum 2 milligrams (mg) with an expiration date of December 2024. On February 23, 2026, 10:24 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated they disposed of expired medications in a liquid solution. CNS-C stated they reviewed the resident's medication bins and looked at medication expiration dates weekly.	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER JOY LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 430 NIAGARA LANE NORTH PLYMOUTH, MN 55447			
(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
01890	Continued From page 56 CNS-C stated they missed the nicotine gum because they paid more attention to expiration dates on prescription medication than over the counter medications. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated discontinued medications may be kept until the expiration dates if there was a possibility of resuming the medication. If not resumed before the expiration date, it would be disposed of according to this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



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

Page: 1

Establishment Info

JOY LIVING INC
430 NIAGARA LANE NORTH
Plymouth, MN 55447
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35819

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

Inspection Info

Report Number: F7994261044
Inspection Type: Full - Single
Date: 2/23/2026 Time: 12:36:05 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 3
Delivery:

New Order: 4-200 Equipment Design and Construction

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

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: Storage totes were being used as food containers. Provide approved food containers.

Comply By: 2/23/2026 Originally Issued On: 2/23/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: No thermometer or test strips were found on site. Provide test strips and test the dishwasher regularly.

Comply By: 2/23/2026 Originally Issued On: 2/23/2026

New Order: 4-500 Equipment Maintenance and Operation

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: Freezer portion of the kitchen fridge is not working. A repair request has been submitted to the owner of the house.

Comply By: 2/23/2026 Originally Issued On: 2/23/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.11 *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

COMMENT: Provide an approved soap dispenser for the handwash sink.

Comply By: 2/23/2026 Originally Issued On: 2/23/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.14A *Priority Level: Priority 3 CFP#: 10*

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: Provide an approved handwash sign for the handwash sink.

Comply By: 2/23/2026 Originally Issued On: 2/23/2026

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

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 F7994261044 from 2/23/2026



Establishment Representative

Crystal Elva, REHS, MS, BS
Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version EH Manager; RPT: F7994261044			Food Establishment Inspection Report			Page 1 of 1			
 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164			No. of Risk Factor/Intervention/Violations		1	Date: 2/23/2026			
			No. of Repeat Risk Factor/Intervention/Violations			Time: 12:36:05 PM			
			Score (optional)			Dur: min			
Establishment: JOY LIVING INC		Address: 430 NIAGARA LANE NORTH		City/State: Plymouth, MN		Zip: 55447		Phone:	
License/Permit #: HFID 35819		Permit Holder:		Purpose of Inspection: Full		Est. Type:		Risk Category:	
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS									
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation				
Compliance Status			COS	R	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	IN	Certified Food Protection Manager			19	N/A	Proper reheating procedures for hot holding		
Employee Health					20	N/A	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	N/A	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	IN	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	N/A	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	IN	Hands clean and properly washed			26	N/A	Pasteurized foods used; prohibited foods not offered		
9	IN	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	OUT	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	IN	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	IN	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	IN	Food separated and protected							
16	IN	Food-contact surfaces; cleaned & sanitized							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							
GOOD RETAIL PRACTICES									
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" or OUT in box if numbered item is not in compliance			Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation						
			COS	R				COS	R
Safe Food and Water					Proper Use of Utensils				
30	N/A	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/A	Plant food properly cooked for hot holding			47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	IN	Approved thawing methods used			48	X	Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
					58		Compliance with licensing and plan review		
Inspector (signature)					Follow-up: Follow-up Date:				

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL35819016-0	Date: 2/23/2026
Facility Name: Joy Living LLC	
Facility Address: 430 Niagara Lane, Minneapolis MN 55447	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Occupancy separation shall be provided in Group I and Group R occupancies. Existing wood lath and plaster in good condition or ½ inch gypsum wallboard is acceptable where one hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

Comments: The attached garage space did not have a proper fire barrier. The wall that separated the living space from the garage had exposed studs and insulation on the garage side offering no fire barrier to the rest of the facility.

3. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments: Inside resident room 4, the chair and desk were partially blocking the room's only egress window.

4. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: In the upstairs hallway the licensed assisted living director (LALD)-D tested the carbon monoxide (CO) detector located on the ceiling at the top of the stairs. It failed to alarm. None of the smoke alarms in the house were not equipped with CO detection.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: There was not a smoke alarm installed inside resident room 3. The mounting bracket was present. The alarm could not be located at the time of the survey.

2. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: There was not a smoke alarm installed in the upstairs hallway outside resident room 3. The mounting bracket was present. LALD-D could not locate the alarm during the survey.

3. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested that LALD-D test the smoke alarms during the facility tour. The smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

-
1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguishers in the basement and upstairs hallway did not have proper annual service tag. Extinguishers were tagged in October 2024.

2. Portable fire extinguishers have a minimum 2-A:10-B:C rating within Group R-3 occupancies and travel distance to the nearest fire extinguisher does not exceed 75 feet. [Minn. Stat. 144G.45 subd.2]

Comments: One fire extinguisher located in the main living room on the south wall and one mounted inside resident room 3 were 1-A:10-B:C rated.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

-
1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments: There were holes in the drywall behind several doors throughout the facility.

The bathroom exhaust fans did not work in both the main level and upstairs bathrooms.

Resident bedroom 3 had excessive staining on the carpet.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: No evacuation map was included in the fire safety and evacuation plan (FSEP)

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

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step.

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

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

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-D was unable to provide employee training records when requested.

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

Comments: LALD-D was unable to provide evacuation drill records for the past year when requested.