



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 16, 2025

Licensee

Rose Arbor - Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN 55311

RE: Project Number(s) SL21387016

Dear Licensee:

On September 25, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 4, 2025. 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 'Kelly Thorson'.

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

AH



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

NOTICE OF EXTENSION OF CONDITIONAL LICENSE

Electronically Delivered

August 15, 2025

Licensee
Rose Arbor/Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN 55311

RE: Conditional License Number 417485
Health Facility Identification Number (HFID) 21387
Project Number(s) SL21387016

Dear Licensee:

Please Note: This letter amends the previous letter dated August 15, 2025. Specifically, there was a typo found in the total amount of fines assessed. The total has been corrected in this letter and no other changes have been made.

On July 30, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 4, 2025. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is extending the conditional assisted living facility license with dementia care for an additional 60-days, due to expire on **October 14, 2025**.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 4, 2025, found not corrected at the time of the July 30, 2025, follow-up survey and/or

subject to penalty assessment are as follows:

1350-Temporary Staff-144g.60 Subd. 5 - \$1,000.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) - \$500.00
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on July 30, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders 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.

CONDITIONAL LICENSE ISSUED:

MDH will extend the conditional assisted living with dementia care facility license for Rose Arbor/Wildflower Lodge, for an additional 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Rose Arbor/Wildflower Lodge is in substantial compliance.

The following condition has been removed, effective August 15, 2025:

- a. **No new admissions:** Rose Arbor/Wildflower Lodge will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Rose Arbor/Wildflower Lodge must provide the Department:
 - i. A list of the names and birthdates of any individuals Rose Arbor/Wildflower Lodge is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

The following conditions will continue to be in effect on the conditional assisted living facility with dementia care license:

- b. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- c. **Consultant:** Rose Arbor/Wildflower Lodge will continue to contract with an RN to provide consultation concerning all resident(s) to whom Rose Arbor/Wildflower Lodge provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Rose Arbor/Wildflower Lodge. The consultant will continue to conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must continue to not have any affiliation with Rose Arbor/Wildflower Lodge. Rose Arbor/Wildflower Lodge is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Rose Arbor/Wildflower Lodge in an effort to help Rose Arbor/Wildflower Lodge align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written

reports to MDH noting progress toward substantial compliance and/or concerns about observations. Rose Arbor/Wildflower Lodge will continue to develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. Reports:** The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Rose Arbor/Wildflower Lodge and the RN consultant about a change. Each report will be electronically submitted to: HRDConsultantReports.MDH@state.mn.us. The content of the reports will include information such as:

- i. Progress towards correction of orders;
- ii. Observations of staff delivering assisted living services and the level of competency observed;
- iii. Conversations with residents and family members about satisfaction with assisted living services;
- iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
- v. Overall impressions about the quality of the assisted living services delivered;
- vi. Overall impressions about the dignity with which the residents and their family members are treated;
- vii. Concerns; and
- viii. Any other information requested by the Department or considered important by the RN consultant(s).

- e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Rose Arbor/Wildflower Lodge to correct the violations cited during the follow-up survey as well as to determine the overall practice of Rose Arbor/Wildflower Lodge in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

- f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

- g. Corrective Action Plan:** Rose Arbor/Wildflower Lodge will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

- i. A statement of the concern
- ii. A description of what will happen to correct the concern
- iii. A target date for when each correction will be complete
- iv. Who is responsible to make sure it happens
- v. Current status of correction work
- vi. Description of a plan to monitor and ensure ongoing substantial compliance for

each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Rose Arbor/Wildflower Lodge is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional license period. If MDH determines Rose Arbor/Wildflower Lodge is in substantial compliance on the follow up survey, MDH will remove the conditions from Rose Arbor/Wildflower Lodge's assisted living facility license, and Rose Arbor/Wildflower Lodge will correct any outstanding violations identified during the survey. If Rose Arbor/Wildflower Lodge is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

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

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 Kelly Thorson directly at: 320-223-7336.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH



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- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
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REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

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If you have any questions, please contact Kelly Thorson directly at: 320-223-7336.

Sincerely,

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

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/30/2025
NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL21387016-1 On July 28, 2025, through July 30, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on Aptil 4, 2025. At the time of the survey, there were 97 residents; 79 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{01350} SS=I	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing	{01350}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/30/2025
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{01350}	Continued From page 1 agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure contracted staff met all requirements for training and competency evaluation, as identified in 144G.60, Subd. 4 and 144G.61 Subd 1. and 2, for two of two unlicensed personnel ((ULP)-Z and ULP-AA). This had the potential to affect all residents receiving medication and treatment services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 July 28, 2025, licensed assisted living director in residency (LALDIR)-X provided an untitled roster of 69 staff who were identified as agency or temporary staff who worked for the licensee in various direct care roles. On July 30, 2025, at 9:45 a.m., LALDIR-X provided ULP-Z and ULP-AA's records. LALDIR-X stated some training for both ULPs was provided by the agency who provided ULP-Z and ULP-AA as temporary staff.	{01350}			

Minnesota Department of Health

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{01350}	Continued From page 2 ULP-Z and ULP-AA were identified as orientated by licensee on April 18, 2025, and May 12, 2025, respectively. ULP-Z's record lacked evidence of medication administration training, competency testing, and a 30-day supervision by a registered nurse (RN) to ensure ULP-Z was competent to perform medication administration services. ULP-AA's record lacked evidence of medication administration training, competency testing, and a 30-day supervision by a RN to ensure ULP-AA was competent to perform medication administration services. On July 30, 2025, at 10:45 a.m., LALDIR-X, clinical nurse supervisor (CNS)-BB, and interim CNS-D stated licensee had used many temporary staff from multiple different agencies. CNS-BB stated licensee was not aware each temporary staff were required to have full records with all required orientation, training, competency testing, and supervision like licensee's other full time regular staff. CNS-BB stated licensee did not have an RN provide medication administration training and competency training to any temporary staff. ICNS-D stated licensee would need to audit all temporary staff records and complete all training, competency testing, and supervision for each prior to providing services. The licensee's Conditional License Report dated July 14, 2025, indicated on page 23 for citation 1350 (this citation) the licensee would develop a plan to audit and ensure all temporary staff would receive the required onboarding and orientation starting the week of July 14, 2025. The licensee's 4.05 Employee Records policy	{01350}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/30/2025
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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
{01350}	Continued From page 3 dated February 28, 2024, indicated the licensee would maintain an up-to-date employee file with all required content for all employees. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated February 28, 2024, indicated each employee would receive all required training, orientation, and evidence would be maintained in the employee file prior to provision of services to a resident. No further information provided.	{01350}			
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for one of five residents (R7). This practice resulted in a level two violation (a violation that did not harm a client'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: R7 was admitted to the licensee on February 24, 2025. On July 30, 2025, at 9:30 a.m., interim clinical nurse supervisor (ICNS)-D provided R7's unsigned service plan date July 30, 2025, and included a handwritten note from ICNS-D which read, "We [licensee] do not have [sic] current signed service plan." On July 30, 2025, at 10:00 a.m., ICNS-D stated licensee had updated R7's service plan but had not obtained authentication on the current service plan. ICNS-D stated licensee was going to meet with R7 and their designated representative to have them authenticate the service but did not have a current service plan authenticated for the services provided yet.	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 5 The licensee's Conditional License Report dated July 14, 2025, indicated on page 29 for citation 1640 (this citation), the licensee had audited all service plans and noted service plans lacked required content. The licensee's plan was to update each service plan with the next assessments, but R7's service plan lacked authentication. The licensee's 6.08 Service Plan policy dated February 28, 2024, indicated services plans and any revisions would include authentication by the licensee and the resident or the resident's designated representative. No further information provided.	{01640}			
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 6 appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R5 and R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R5 R5 was admitted on October 26, 2023. R5's Physician's Orders signed by R5's primary care physician on July 23, 2025, included an order which read, "Compression stockings. Staff to apply compression stockings to bilateral lower extremities (both legs) in the morning and remove	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 7 at bedtime for edema (swelling or excess fluid in the body)." R5's Resident Assessment for [R5] dated July 23, 2025, indicated on page three (3) R5 had enhanced needs with the assistance with R5's Ted hose for application and removal. R5's Service Plan signed July 25, 2025, indicated R5 required services for the assistance with TED (thromboembolic deterrent stockings) hose. R5's TAR (treatment administration record) dated for July 2025, indicated staff assisted R5 with the application and removal of R5's compression stockings. The TAR lacked specific instructions or indications when unlicensed personnel (ULP) would not apply the TED hose and when to contact a licensed health professional. R10 R10 was admitted on October 29, 2024. R10's Service Plan signed July 23, 2024, indicated R10 required assistance with management of R10 indwelling catheter (a small tube placed into the urethra and into the bladder which drains into a collection bag for urine) every morning and evening to alternate between a day bag and night bag. R10 Resident Assessment for [R10] dated July 23, 2025, indicated staff would alternate R10's catheter bag between day and night bags as appropriate. R10's Personal Care list dated July 2025, indicated R10 received the services of alternating R10's catheter bag from the day bag to night bag daily. The Personal Care list lacked instructions	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 8 or indication for when ULPs would not change the bag or when to contact a nurse based on the contents of the bag. On July 29, 2025, at 9:45 a.m., interim clinical nurse supervisor (ICNS)-D stated both R5 and R10's treatment records should have included instructions and indications when both resident's treatments should not be completed and when to contact a licensed health professional. ICNS-D stated all staff are trained on appropriate administration of the treatments, but each specific resident record did not include the specific instructions. The licensee's Conditional License Report dated July 14, 2025, indicated on page 36 for citation 1940 (this citation), the licensee had audited all treatment plans and noted treatment plans lacked required content. The licensee's plan was to update each treatment plan with the next assessments, but R5 and R10's treatment plans were not updated with the current assessments completed. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated February 28, 2025, indicated each resident's individualized treatment management plan would include any specific instructions for each resident and document those instructions in the record. No further information provided.	{01940}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

June 2, 2025

Licensee
Rose Arbor/Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN 55311

RE: Conditional License Number 417485
Health Facility Identification Number (HFID) 21387
Project Number(s) SL21387016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, Subd. 1 (a), MDH is issuing a 60-day conditional license pending appeal under Minn. Stat. § 144G, Subd. 18.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 for widespread violations;

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

St - 0 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$500.00
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00
St - 0 - 1350 - 144g.60 Subd. 5 - Temporary Staff - \$3,000.00
St - 0 - 1420 - 144g.62 Subd. 2 - Delegation Of Assisted Living Services - \$3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$14,000.00.** 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 and immediately correct any reissued orders 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. If you request a hearing, please specify whether you are appealing the orders and fines, the imposed conditions, or both.

CONDITIONAL LICENSE ISSUED:

MDH will issue Rose Arbor/Wildflower Lodge a conditional assisted living facility license for 60 calendar days, pending appeal. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Rose Arbor/Wildflower Lodge is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Rose Arbor/Wildflower Lodge will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Rose Arbor/Wildflower Lodge must provide the Department:
 - i. A list of the names and birthdates of any individuals Rose Arbor/Wildflower Lodge is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Rose Arbor/Wildflower Lodge will contract with an RN to provide

consultation concerning all resident(s) to whom Rose Arbor/Wildflower Lodge provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Rose Arbor/Wildflower Lodge. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Rose Arbor/Wildflower Lodge and MDH must review the RN's credentials and approve the selection. Rose Arbor/Wildflower Lodge is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Rose Arbor/Wildflower Lodge in an effort to help Rose Arbor/Wildflower Lodge align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Rose Arbor/Wildflower Lodge will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Rose Arbor/Wildflower Lodge and the RN consultant about a change. Each report will be electronically submitted to: HRDConsultantReports@state.mn.us. The content of the reports will include information such as:
- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Rose Arbor/Wildflower Lodge to correct the violations cited during the survey as well as to determine the overall practice of Rose Arbor/Wildflower Lodge in meeting the needs of the people it serves. In addition, the Office of

Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

- f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. Corrective Action Plan:** Rose Arbor/Wildflower Lodge will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Rose Arbor/Wildflower Lodge is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional license period. If MDH determines Rose Arbor/Wildflower Lodge is in substantial compliance on the follow up survey, MDH will remove the conditions from Rose Arbor/Wildflower Lodge's assisted living facility license, and Rose Arbor/Wildflower Lodge will correct any outstanding violations identified during the survey. If Rose Arbor/Wildflower Lodge is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit

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

If you request a hearing, please specify whether you are appealing the orders and fines, the imposed conditions, or both.

Rose Arbor/Wildflower Lodge

June 2, 2025

Page 6

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 Kelly Thorson directly at: 320-223-7336.

Sincerely,

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

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

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0 000	Initial Comments 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: SL21387016-0 On March 31, 2025, through April 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 107 resident(s); 88 receiving services under the Assisted Living Facility with Dementia Care license. On March 31, 2025, an immediate correction order was identified and issued for SL21387016-0, tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged. On April 1, 2025, an immediate correction order was identified and issued for SL21387016-0, tag identification 1350. During the course of the survey, the licensee took	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 action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged. On April 2, 2025, an immediate correction order was identified and issued for SL21387016-0, tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged. On April 3, 2025, an immediate correction order was identified and issued for SL21387016-0, tag identification 1420. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000			
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of facility space by a vendor to provide therapy services to residents. 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	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
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0 100	Continued From page 3 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 March 31, 2025, at 10:45 a.m., during facility tour, surveyor noted a therapy office space on the second floor of the assisted living building, near the nurse's office. On March 31, 2025, at 4:12 p.m., associate executive director (AED)-E sent via email a lease agreement between licensee and a contracted outside therapy management company. The lease agreement was in effect from August 1, 2024, through July 31, 2025. On April 3, 2025, at 11:08 a.m., via email, licensed assisted living director (LALD)-C indicated they had a lease agreement with the contracted outside therapy management company. On April 3, 2025, at 5:19 p.m., LALD-C stated, "I didn't know we couldn't have therapy lease a room here, I sent an email to [surveyor's supervisor] asking how to get a variance, so we are working on that." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			

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0 330	Continued From page 4	0 330			
0 330 SS=F	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 interview and record review, the licensee failed to fully cooperate with the survey when the licensee did not provide assessments, policies, personnel records, and resident records to representatives of the Department within a reasonable period of time. This deficient practice had the potential to include all residents and staff. 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 March 31, 2025, at 8:31 a.m., the surveyor emailed the facility after initiating survey, and requested the current resident roster, discharge roster, and employee roster be available during	0 330			

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0 330	Continued From page 5 the entrance conference. On March 31, 2025, at 9:45 a.m., during the entrance conference, surveyor requested the current resident roster, discharge roster, and employee roster. Licensed assisted living director (LALD)-C stated, "We are still working on putting those together for you." Surveyor also requested the policy binder, emergency preparedness binder, Tuberculosis (TB) risk assessment and staff schedule for the week. On March 31, 2025, at 10:42 a.m., surveyor requested via email current resident roster, discharge roster, employee roster, policy binder, emergency preparedness binder, Tuberculosis (TB) risk assessment and staff schedule for the week. On March 31, 2025, at 12:03 p.m., via email, surveyor requested employee files for unlicensed personnel (ULP)-K and ULP-M. On March 31, 2025, at 1:57 p.m., via email, surveyor made a fourth request for the current resident roster and discharge roster. On March 31, 2025, at 4:22 p.m., surveyor requested via email, "We will need the resident roster emailed to this chain by 8:00 p.m. today." On March 31, 2025, at 4:50 p.m., surveyor requested verbally to LALD-C to get the current resident roster, discharge roster, employee files for ULP-K and ULP-M, and TB risk assessment. Surveyor requested these items be emailed so they would be readily available at the start of the day. LALD-C stated, "Oh yes we will get those to you."	0 330			

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0 330	Continued From page 6 On April 1, 2025, at 7:40 a.m., Surveyor requested above mentioned items from LALD-C. LALD-C stated, "We are just starting to create the rosters so we will get those to you as soon as we are done with them." On April 1, 2025, at 8:03 a.m., surveyor sent an email that read, "Greetings, Sending an email with previous requested and newly requested items. Per our conversation at 7:40 a.m. we still need -a current resident roster that includes all necessary information -employee files for ULP-K and ULP-M the two agency staff that worked last night and today." as well as requesting R8's file and then indicated, "I know per our conversation this morning you are just starting to create the roster, so if we could please have all of these other requested items by 9:00 a.m., and the roster by 10:00 a.m. Thank you." Throughout the course of the survey, the surveyors continued to request employee files, resident files, and all necessary documentation needed for review, however, as of April 4, 2025, at 10:46 a.m., at the time of the survey completion, the surveyors had not been supplied with the current client roster that had all the necessary items, policies, and several employee and resident documents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 340 SS=F	144G.30 Subd. 5 Correction orders	0 340			

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0 340	Continued From page 7 (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 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 have sufficient documentation with actions taken to comply with correction orders (tag identification: 0650, 0660, 0680, 0970, 1290, 1420, 1470, 1540, 1620, 1730, 1790, 1820, 1880, 1890, 1940, 2040, 2110, 2170, and 2310) for a survey completed on April 20, 2023. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a	0 340			

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0 340	Continued From page 8 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: During the survey on March 31, 2025, through April 4, 2025, the surveyor reviewed the licensee's policies and procedures, reviewed resident records, and conducted observations and interviews with licensed assisted living director (LALD)-C and interim clinical nurse supervisor (ICNS)-D. The licensee lacked evidence to indicate the orders issued during the April 20, 2023 survey were corrected. The licensee lacked documentation of a plan of correction, or any actions taken to indicate correction orders previously cited on April 20, 2023, were in full compliance with assisted living care statutes. On March 31, 2025, at 9:37 a.m., LALD stated they were hoping survey would not have so soon as they were making improvements from previous survey, but still had more improvements to make. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			

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0 420	Continued From page 9	0 420			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services 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 observation, 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 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: The licensee had an assisted living with dementia care license, effective June 17, 2024. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that,	0 420			

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0 420	Continued From page 10 as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota 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 believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page four was electronically signed by the authorized agent on June 17, 2024. As a result of this survey, the following orders were issued under 0100, 0330, 0340,0420, 0470, 0500, 0510, 0550, 0640, 0650, 0660, 0680, 0720, 0730, 0775, 0800, 0810, 0910, 0920, 0940, 0970, 1060, 1290, 1350, 1370, 1380, 1420, 1440, 1460, 1470, 1490, 1500, 1540, 1610, 1620, 1640, 1730, 1760, 1790, 1810, 1820, 1830, 1880, 1890, 1910, 1940, 1950, 1970, 2040, 2110, 2130, 2170, 2260, 2310, 2320, 2350, 2410, and 3090, 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 provided.	0 420			

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0 420	Continued From page 11	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: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation	0 470			

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0 470	Continued From page 12 completed by the clinical nurse supervisor in accordance with Minnesota Administrative Rule 4659.0180 Subpart 3., at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 3, 2025, at 8:27 a.m., the receptionist provided the [licensee] staffing plan binder that contained a staffing plan which was created on July 23, 2024. The staffing plan lacked evidence of staffing metrics used to determine appropriate staffing levels and evidence of being reviewed twice per year. On March 31, 2025, at 9:45 a.m., during the entrance conference, associated executive director (AED)-E stated "usually [LALD-C] and I work on that together." On April 2, 2025, at 8:33 a.m., AED-E stated, "what is in there (the staffing plan binder) is what we have." The licensee's 4.06 Staffing & Scheduling policy, revised February 28, 2024, indicated, "1. The clinical nurse supervisor will develop and	0 470			

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0 470	Continued From page 13 implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. 2. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract b. Each resident's acuity level, as determined by the most recent assessment or individualized review c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises d. Whether the facility has a secured dementia care unit, and e. Staff experience, training, and competency." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or	0 500			

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0 500	Continued From page 14 services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 500			

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0 500	Continued From page 15 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 March 31, at 8:30 a.m., the surveyor emailed the licensee that an onsite assisted living facility survey would be initiated on March 31, 2025, at 9:30 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee failed to provide the following policies and procedures during or after the survey process: - process for evaluating staff performance. From March 31, 2025, through April 4, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On April 3, 2025, at 8:33 a.m., associate executive director (AED)-E indicated the surveyors had been given all the policies to the best of her knowledge. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
(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
0 510	Continued From page 16 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by three of six employees (unlicensed personnel (ULP)-M, ULP-R and ULP-W). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-M On April 1, 2025, at 6:58 a.m., surveyor observed ULP-M enter R8's room without performing hand hygiene and assisted R8 with getting out of bed	0 510			

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0 510	Continued From page 17 and assisted R8 with dressing. ULP-M then took R8 to the bathroom and applied gloves and transferred R8 to the toilet, and then emptied the trash in the bathroom. ULP-M then removed R8's urine soiled brief and placed it on the bathroom floor. ULP-M then provided peri care to R8 and placed a clean brief on R8 and pulled up their pants and transferred them into the wheelchair. ULP-M then picked up the soiled brief from the floor, placed it into the trash, removed gloves and washed hands. ULP-R On April 3, 2025, from 1:01 p.m., through 1:10 p.m., surveyor observed ULP-R to enter R10's room. Without preforming hand hygiene ULP-R donned gloves. ULP-R cleaned R10's catheter spicket and emptied R10's overnight catheter bag. ULP-R then removed gloves and without preforming hand hygiene donned new gloves and changed R10's overnight catheter bag to a leg bag. ULP-R then doffed gloves and preformed hand hygiene. ULP-W ULP-W entered R9's room and administered scheduled morning medications, put on gloves, applied Diclofenac gel as ordered, and removed gloves. Without putting on gloves, ULP-W assisted R9 to the bathroom and removed R9's overnight brief, placing the soiled brief directly on the floor. ULP-W then assisted R9 to put on a new brief and completed morning activities of daily living (ADLs). With stand-by assistance, ULP-W escorted R9 to the dining room for breakfast before performing hand hygiene. On April 2, 2025, at 9:02 a.m., ULP-W stated they	0 510			

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0 510	Continued From page 18 were trained to complete hand hygiene before and after medication administration, between glove changes, and before and after serving food. Furthermore, they were trained to wear gloves while performing cares while in resident rooms. On April 3, 2025, at 1:10 p.m., ULP-R stated, "We should wash our hands when they are visibly soiled, and after cares." On April 3, 2025, at 4:17 p.m., interim clinical nurse supervisor (ICNS)-D stated, 'We do have the hand hygiene class, and it is educated on med pass and observations, so it is something the staff are trained on.' ICNS-D also stated, "Change your task change your gloves, hand hygiene in between each and every resident." The licensee's 8.07 Gloves policy, revised February 28, 2024, indicated, "gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed." The licensee's 8.09 Hand washing policy, revised February 28, 2024, indicated, "Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550			

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0 550	Continued From page 19 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 the required information related to the grievance procedure. This had the potential to affect all the licensee's current 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 31, 2025, at 9:30 a.m., the surveyor observed complaint reporting information in a frame located inside the assisted living, in an alcove located to the right of the main entrance	0 550			

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0 550	Continued From page 20 door. The posting included prior licensed assisted living director's (LALD) name and facility phone number. The posting lacked current LALD name and email address. On March 31, 2025, at 11:05 a.m., the surveyor observed complaint reporting information in a frame located next to the memory care secured entrance. The posting included prior licensed assisted living director's (LALD) name and facility phone number. The posting lacked current LALD name and email address. On April 2, 2025, at 3:12 p.m., LALD-C acknowledged they were unaware the complaint posting required an email address and phone number. The licensee's 2.09 Complaint/ Grievance policy, revised February 28, 2024, indicated, "A facility complaint form should be filled out by the resident, resident representative, or employee and given to the supervisor of the department or to the Assisted Living Director." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 640 SS=C	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	0 640			

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0 640	Continued From page 21 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas, including posting the 911 emergency number and contact information for Minnesota Adult Abuse Reporting Center (MAARC) in common areas on the main floor of the facility. This had the potential to affect residents, staff and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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: On March 31, 2025, at 9:30 a.m., upon entering the facility, the surveyor did not observe the required postings of 911 emergency number near public phones located in common areas throughout the building or required content for MAARC reporting and complaint postings. On April 2, 2025, at 3:12 p.m., licensed assisted living director (LALD)-C acknowledged the phones in memory care are accessible but stated	0 640			

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0 640	Continued From page 22 911 isn't posted on or near them because the residents will think they are supposed to call that number. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 650			

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0 650	Continued From page 23 review, the licensee failed to ensure employee records included all required content for five of five employees (unlicensed personnel (ULP)-B, ULP-Q, ULP-R, ULP-T, ULP-U). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents. ULP-B's record lacked the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct care services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-Q's employee record lacked the following required content: - records of competency evaluations to include medication administration for each route and the delegated task of blood glucose monitoring;	0 650			

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0 650	Continued From page 24 - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of the background study. Although documentation of the background study was not found in ULP-Q's employee record, the completion of the background study was verified by looking online at NetStudy 2.0 roster. On April 2, 2025, at 11:06 a.m., ULP-Q stated they had been trained by a nurse in a three day class on medications, and they were competency trained on blood glucose monitoring by interim clinical nurse supervisor (ICNS)-D. ULP-R ULP-R had a hire date of May 7, 2024, and provided direct care services to residents. ULP-R's employee record included page three of their signed job description; however, the first two pages were not in the record. ULP-R's employee record lacked the following required content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-T's employee record lacked the following required content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of the background study. ULP-U	0 650			

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0 650	Continued From page 25 ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-U's employee record lacked the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On April 3, 2025, at 8:30 a.m., associate executive director AED-E stated, "Everything we have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., ICNS-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." The licensee's 4.05 Employee Records policy, revised February 28, 2024, indicated, "Employee records for each person will include: - Evidence of current professional licensure, registration or certificate, if required - Records of all training and in-service education required and/or provided including record of competency testing as required - Current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any - Documentation of annual performance reviews that identify areas of improvement needed and training needs	0 650			

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0 650	Continued From page 26 - For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file) - Documentation of a completed criminal background study - Evidence that a reference check has been completed - Verification of completed orientation and annual training and competency testing as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis 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	0 660			

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0 660	Continued From page 27 by: Based on interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure a current facility TB risk assessment had been completed, and history and failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for four out of five employees, (unlicensed personnel (ULP-B, ULP-Q, ULP-T, and ULP-U) with employee records reviewed. 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: ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents. ULP-B's record included completed Baseline TB Screening Tool for healthcare worker (HCW), dated, October 9, 2023, indicated ULP-B had a negative TB skin test completed on March 28, 2023. ULP-B's employee record lacked evidence of TB training on hire, annual TB training for 2024, and baseline TB testing completed on or within ninety	0 660			

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0 660	Continued From page 28 days prior to their hire date with the licensee. ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct services to residents. ULP-Q's employee record included completed Baseline TB Screening Tool for HCW dated November 6, 2024. ULP-Q's employee record lacked evidence of TB training upon hire and baseline TB testing completed on or within ninety days prior to their hire date with the licensee. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-T's employee record included completed Baseline TB Screening Tool for HCW dated November 19, 2024. ULP-T's employee record lacked evidence of TB training upon hire and baseline TB testing completed on or within ninety days prior to their hire date with the licensee. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-U's employee record included a completed Baseline TB Screening Tool for HCW dated January 30, 2024. ULP-U's employee record lacked evidence of TB training on hire, annual TB training for January 2025, and baseline TB testing completed on or within ninety days prior to their hire date with the	0 660			

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0 660	Continued From page 29 licensee. On April 2, 2025, at 5:10 p.m., interim clinical nurse supervisor (ICNS)-D provided surveyor with an incomplete facility TB risk assessment dated March 31, 2025, after the start of survey. ICNS-D stated, ""This is what we have so far, I'm not sure why [LALD] hasn't completed." The licensee's 8.16 Tuberculosis Screening policy, revised February 28, 2024, indicated "The facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health." Additionally, the policy indicated, "Staff will be educated regarding TB at time of hire. The content of the training should be appropriate to the job responsibilities and educational or professional background of the employee (licensed versus unlicensed staff)." The policy also indicated, "New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. Staff TB screening results will be kept in each employee medical file." The CDC's Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 17, 2023, recommended all United States health care personnel should have a completed a TB risk assessment, symptom evaluation, TB testing for tuberculosis, with additional working for TB disease with a positive test results or symptoms compatible with TB	0 660			

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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
0 660	Continued From page 30 disease. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the	0 680			

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0 680	Continued From page 31 licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license. 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 lacked evidence of having an emergency disaster preparedness plan that contained the following required content: - develop and maintain an EP plan and be updated annually, must document date of review and any updates made to the plan based on the review; - documentation of a risk assessment that considers hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - quarterly review of missing resident policy; - identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - develop P/P that must address: use of volunteers, including the process/role for	0 680			

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0 680	Continued From page 32 integration; - evidence of evacuation process and locations; and - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. On March 31, 2025, at 2:43 p.m., licensed assisted living director (LALD)- C stated, "I know there is a missing person quarterly review, but I don't know where it is. I have been working on this whole emergency preparedness plan since I got here, and I couldn't finish it before you came. I am sure some of the documents exist, but I don't know where at this point." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident records were readily available to contract (pool) staff	0 720			

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0 720	Continued From page 33 when services completed by pool staff required access to the records. This could affect all resident records pool staff document in. 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: Unlicensed personnel (ULP) that were hired directly by the licensee, were documenting in resident charts for cares, tasks, and medication administration that was completed by ULP's who were contracted in through an agency service. Licensee failed to ensure agency staff had access to accurately document cares provided under their credentials. On April 1, 2025, at 6:51 a.m., ULP-M stated, "This is my first day and I have not gotten any training except this piece of paper right here (paper had five room numbers that ULP-M was to do cares on) I have not had any other training except I was shown where the break room was." On April 1, 2025, at 6:52 a.m., ULP-M stated to ULP-O "I was told when I am done getting the resident up I should tell the aide working on the cart so you can chart it." On April 1, 2025, at 6:53 a.m., ULP-O stated to ULP-M, "No problem I can tell you who gets a shower and I will call [clinical coordinator (CC)-G]	0 720			

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0 720	Continued From page 34 to get you a phone so you can answer call lights, just let me know when you are finished with each person and I will get it documented for you. On April 3, 2025, at 6:40 a.m., ULP-N stated, " I had to do her (ULP-K) charting because she didn't have access to charting. Sometimes the agency staff have access to charting and then sometimes they don't. I don't really know how that works, but if they don't have access then we have to chart for them." Statute 144G.43 Subd. 1 (c) (2) indicates contractors of a facility may have access to resident records in order to provide services to the resident. The licensee's 2.38 Resident Record - Information and Content policy, dated February 28, 2024, indicated, "[Licensee] will maintain appropriate and accurate records for each resident that is receiving assisted living services. All entries in the resident records must be current, legible, permanently recorded, dated and authenticated with the name and title of the person making the entry." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 720			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number;	0 730			

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0 730	Continued From page 35 (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this	0 730			

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0 730	Continued From page 36 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 was admitted to the licensee and began receiving services on August 31, 2021. R1 discharged on January 21, 2025. R1's records included a discharge summary dated January 21, 2025, the discharge summary lacked: - a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status;	0 730			

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0 730	Continued From page 37 - a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and - a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On April 1, 2025, at 1:50 p.m., interim clinical nurse supervisor (ICNS)-D stated "R1's discharge summary is lacking a lot of information and I am not sure why because it was completed before I started here. I'm sure any recent discharges looked similar. My expectation would be a nurse completes a discharge, handles medications, and completes hand-off report to next facility." The licensee's resident discharge policy was requested multiple times, and no policy was received. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 775 SS=F	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	0 775			

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0 775	Continued From page 38 by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents) The findings include: On April 2, 2025, from 10:00 a.m. to 3:30 p.m., the surveyor toured the facility with director of maintenance (DOM)-P, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: EXIT DOOR LOCKING and PATH OF EGRESS: The Wildflower Lodge central exit stairwell had metal gates with electromagnetic locks and key-code pads that locked the gate from the direction of exit travel installed at the top and bottom of each flight of stairs on all three levels. The upper-level cross-corridor door adjacent to apartment 211 (Wolf wing) and the main level cross-corridor door adjacent to apartment 119 (Bear wing) had an electromagnetic lock installed at the top of each door. The path of egress to exit Wolf wing and Bear wing requires the building occupant to pass through more than one door or gate equipped with a controlled egress lock.	0 775			

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0 775	Continued From page 39 The hallway from lower-level storage area had a metal gate with electromagnetic lock and key-code pad that locked the gate from the direction of exit travel installed adjacent to the central exit stairwell. The path of egress to exit the lower-level storage area requires the building occupant to pass through more than one door or gate equipped with a controlled egress lock A building occupant shall not be required to pass through more than one door equipped with a controlled egress lock before entering an exit. EXIT DOOR LOCKING: The Wildflower Lodge was locked with electromagnetic locks and key-code pads that locked all the exit doors from the direction of exit travel. There was not an emergency release button to release all locked doors to open in the direction of exit travel installed anywhere in the facility. DOM-P stated they did not have a remote emergency release button to release all the electromagnetic locks on the exit doors. The egress control locking system at all exterior doors shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. FIRE RESISTANT RATED DOORS The fire-resistant rated doors in the following locations did not close and latch. Wildflower Lodge: - The lower-level stairwell door adjacent to the elevator equipment room. - The main level mechanical room door in Bird wing kitchenette had the closer arm removed.	0 775			

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0 775	Continued From page 40 - The upper-level central stairwell doors on both sides. - The upper-level cross-corridor door adjacent to apartment 211 Rose Arbor: - The second-floor stairwell door adjacent to apartment 222. - The third-floor stairwell door adjacent to apartment 303. - The third-floor stairwell door adjacent to apartment 315. Several fire-resistant rated doors throughout the facility had kick down hold open devises that prevented the doors from closing automatically. The locations included, but were not limited to the following: Wildflower Lodge: - Apartments 38-42 in Deer wing. - Apartments 20-26 in Moose wing. - Apartments 131-133 and 136-139 in Bird wing. - Apartments 119-125 in Bear wing. - Apartments 211-217 in Wolf wing. Rose Arbor: - Apartment 101, 102, 114, 115, 206, 216, 414, 415, 416, 417, 418, 419, 423. - The Dietary office on first floor. - Life Enrichment Office on the third floor. Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency. FIRE RESISTANT SEPARATIONS The second-floor electrical closets adjacent to the elevator lobby and activity room were missing the fire stop and sealant at multiple penetrations	0 775			

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0 775	Continued From page 41 through the rated floor and ceiling assemblies. Fire resistant rated wall penetrations are required to be sealed, and fire stopped. There was a 4-inch by 4-inch hole in the wall of the electrical closet adjacent to the activity room. Fire resistant wall assemblies are required to be maintained and sealed as installed and approved at the time of construction. FIRE SPRINKLER SYSTEM MAINTENANCE The inspection tag in Wildflower Lodge on the automatic fire sprinkler system was dated March 20, 2024. DOM-P stated the automatic fire sprinkler system in Rose Arbor was completed early in 2025, but they did not know why the third-party inspection company did not complete the inspection of the Wildflower Lodge system at the same time they completed the inspection of the Arbor Rose system earlier in 2025. Water based automatic sprinkler systems are required to be inspected, tested, and maintained in accordance with MSFC Section 901 and National Fire Protection Association (NFPA) 25. No sprinkler system maintenance documentation was provided for Wildflower Lodge. These deficient conditions were visually verified at the time of discovery by DOM-P accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800			

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0 800	Continued From page 42 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 and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 April 2, 2025, from 10:00 a.m. to 3:30 p.m., the surveyor toured the facility with director of maintenance (DOM)-P. The following was observed. The basement storage room had standing water on the floor in storage units 28-33. DOM-P opened the doors to a few storage units where water was actively running down the basement wall inside. DOM-P visually verified these deficient findings at	0 800			

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0 800	Continued From page 43 the time of discovery and stated they did not know the water penetration was so significant. 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 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 44 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 2, 2025, director of maintenance (DOM)-P provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "9.06 Fire Policy", dated February 28, 2024, failed to include the following: 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 provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810			

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
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0 810	Continued From page 45 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. The FSEP included standard resident evacuation procedures but 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 the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. DOM-P left the facility before an interview could be completed. No further information was provided. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. DOM-P lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. DOM-P lacked documentation showing any training was offered or training was scheduled for a future date for employees on the fire safety and evacuation plan. DOM-P left the facility before an interview could	0 810			

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0 810	Continued From page 46 be completed. Survey staff requested documentation from interim clinical nurse supervisor (ICNS)-D, but they did not know where any training documentation on the FSEP was stored. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous 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 four of four residents (R2, R6, R13, R15). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 910			

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0 910	Continued From page 47 the residents). The findings include: R2 R2 was admitted to the facility April 19, 2023, and began receiving assisted living services. R2's Assisted Living Contract signed on April 19, 2023, lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility R6 R6 was admitted to the facility August 30, 2024, and began receiving assisted living services. R6's Assisted Living Contract signed on August 30, 2024, lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. R13 R13 was admitted to the facility April 28, 2021, and began receiving assisted living services. R13's Assisted Living Contract signed on April 28, 2021, lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. R15 R15 was admitted to the facility July 28, 2023, and began receiving assisted living services. R15's Assisted Living Contract signed on July 28, 2021, lacked the following required content:	0 910			

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
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0 910	Continued From page 48 - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. On April1, 2025, at 4:30 p.m., associate executive director (AED)-E stated the contract being used was created by corporate on April 9, 2024, but appears to not meet current MN regulations. In addition, AED-E stated, "I doubt if addendums to older contracts were done before. I have not done any." On April 3, 2025, at 10:41 AED-E stated, "We have identified that we are missing these important items and all of that should be in our contracts and we have asked for the new lease and legal has it opened and is going through getting everything put in place, but we need to get new leases out to everyone in the building for the residents to all have leases that meet the Minnesota requirements." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted	0 920			

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0 920	Continued From page 49 amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. 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 (R2, R6, R13) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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: R2's Assisted Living Contract dated April 19, 2023, R6's Assisted Living Contract dated August 30, 2024, R13's Assisted Living Contract dated April 28, 2021, were titled, Residence and Service Agreement. The contracts indicated the licensee	0 920			

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0 920	Continued From page 50 was a Housing and Assisted Living Community and/or Memory Care on the front page, and on the second, a Housing and Assisted Living Community. The license held for Health Facility Identification (HFID) number 21387 is an Assisted Living with Dementia Care License. On April1, 2025, at 4:30 p.m., associate executive director (AED)-E stated the contract being used was created by corporate on April 9, 2024, but appears to not meet current MN regulations. In addition, AED-E stated, "I doubt if addendums to older contracts were done before. I have not done any." On April 3, 2025, at 10:41 AED-E stated, "We have identified that we are missing these important items and all of that should be in our contracts and we have asked for the new lease and legal has it opened and is going through getting everything put in place, but we need to get new leases out to everyone in the building for the residents to all have leases that meet the Minnesota requirements." The Residence and Service Agreement for R2, R6, and R13, depicted at the bottom of the form: Rev. December 23, 2019 (Version 1.4.16). The licensee's 3.01 Assisted Living Dementia Staff Training policy dated February 28, 2024, indicated licensee staff that worked with residents with Alzheimer's disease and other dementias would have proper training for the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 920			

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0 940	Continued From page 51	0 940			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	0 940			

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0 940	Continued From page 52 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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: On April 1, 2025, at 4:30 p.m., the associate executive director (AED)-E stated the blank lease agreement dated April 9, 2024, provided to the surveyor on March 31, 2025, titled Residence and Service Agreement was the contract used for any new admissions to the assisted living facility since that date. The Residence and Service Agreement included the following statement: "The community does not guarantee or promise that at the time that you will need such financial assistance that it will be able to accommodate your residential needs or that the elderly waiver (EW) and community access for disability inclusion (CADI) programs will still be available for use in this community." The Residency Agreement lacked the licensee's information on a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:	0 940			

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0 940	Continued From page 53 - when there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time the limit must be provided. On April 1, 2025, at 4:58 p.m., licensed assisted living director (LALD)-C stated, "We don't accept any CADI and aren't taking new admissions with EW because we already have 49 in house. The facility does not have a defined limit, but we have enough. We will allow residents to age in place." In addition, LALD-C stated that an addendum to current contracts has not been completed for any resident to reflect current EW/CADI limitations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal	0 970			

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0 970	Continued From page 54 property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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: R2 R2 was admitted to the facility April 19, 2023, and began receiving assisted living services. R2's Assisted Living Contract dated April 19, 2023, page 11, section C Indemnification, included the following statement, "you hereby agree to defend, indemnify, hold harmless, and release the Community and its Agents from and against any and all liabilities, losses, costs, expenses, claims, suits, damages, injuries, awards, judgments, and/or responsibilities whatsoever, including, without limitation, legal fees and costs, expert fees, and similar expenses, which may be asserted against, imposed upon, or incurred by the Community." R6 R6 was admitted to the facility August 30, 2024, and began receiving assisted living services. R6's Assisted Living Contract dated August 30, 2024, page 12, section C Liability, included the following statement, "Resident understands that pursuant to Minnesota law, the Community is unlikely to be liable to Resident or Resident's	0 970			

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0 970	Continued From page 55 guests for any injury, death, or property damage occurring in the Apartment Unit or on the Community's premises if such injury, death, or property damage occurs as a result of circumstances created and/or caused by Resident or Resident's guests. Resident further understands that the Community is also unlikely to be liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive, or other services from third-party providers." R13 R13 was admitted to the facility April 28, 2021, and began receiving assisted living services. R13's Assisted Living Contract dated April 28, 2021, page 13, section C Indemnification, included the following statement, "You hereby agree to defend, indemnify, hold harmless, and release the Community and its Agents from ai1d against any and all liabilities, losses, costs, expenses, claims, suits, damages, injuries, awards, judgments, 311d/or responsibilities whatsoever, including, without limitation, legal fees and costs, expert fees, md similar expenses, which may be asse1ted against, imposed upon, or incurred by the Community." R15 R15 was admitted to the facility July 28, 2023, and began receiving assisted living services. R15's Assisted Living Contract dated July 28, 2023, page 13, section C Indemnification, included the following statement, "You hereby agree to defend, indemnify, hold harmless, and release the Community and its Agents from ai1d against any and all liabilities, losses, costs, expenses, claims, suits, damages, injuries,	0 970			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2025
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0 970	Continued From page 56 awards, judgments, 311d/or responsibilities whatsoever, including, without limitation, legal fees and costs, expert fees, md similar expenses, which may be asse1ted against, imposed upon, or incurred by the Community." On April 1, 2025, at 4:30 p.m., associate executive director (AED)-E stated AED was unfamiliar with waivers of liability in the contract and corporate would need to make changes to [licensee] contract to reflect Minnesota requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	01060			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2025
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01060	Continued From page 57 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: 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 (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
(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
01060	Continued From page 58 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: R6's undated and unsigned Service Plan indicated R6 received services to include assistance with meals and medication management. R6's medical record included hospital discharge paperwork that indicated R6 was hospitalized February 2, 2025, through February 5, 2025. R6's medical record lacked an emergency relocation notice to resident and evidence of the emergency relocation notice being sent to the ombudsman. On April 2, 2025, at 5:03 p.m. licensed practical nurse (LPN)-A stated, "I think [associate executive director AED-E] might do them because I know I have to give her the dates whenever someone goes out of the building, but I have not done any." On April 2, 2025, at 5:03 p.m. interim clinical nurse supervisor (ICNS)-D stated, "I remember being told that it was something we needed to do, so I know it is a requirement of the statutes, but I'm not sure if we are doing it, I will have to look." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

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01290	Continued From page 59	01290			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) prior to staff providing services for four of 80 staff, (unlicensed personnel (ULP)-F, clinical coordinator (CC)-G, and dining service chef (DSC)-H and DSC-I). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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	01290			

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01290	Continued From page 60 portion or all the residents). The findings include: On March 31, 2025, at 2:09 p.m., associate executive director (AED)-D provided the surveyor with the licensee's NETStudy 2.0 roster. The surveyor compared the licensee's list of 80 regular employees (non-agency staff) to the NETStudy 2.0 roster. The surveyor found the following staff were not listed on the NETStudy 2.0 roster. ULP-F ULP-F was hired on September 3, 2015, and began providing assisted living services to the licensee's residents on August 1, 2021. ULP-F's employee record lacked evidence of a cleared background study as required. CC-G CC-G was hired on December 13, 2024, to perform administrative services to the licensee's facility. CC-G's employee record lacked evidence of a cleared background study as required. DSC-H DSC-H was hired on July 8, 2024, to perform dietary services to the licensee's facility. DSC-H's employee record lacked evidence of a cleared background study as required. DSC-I DSC-I was hired on December 4, 2024, to perform dietary services to the licensee's facility.	01290			

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01290	Continued From page 61 DSC-I's employee record lacked evidence of a cleared background study as required. On March 31, 2025, at 2:09 p.m., AED-D indicated via email, "Regarding your question on those 4 employees from NetStudy: I searched with their SSN and DOB and this was my results each time. "Your entity is no longer affiliated with this person and you can no longer view this person's profile. You may continue to view prior background study documents for this person on the Recent Documents screen." This happened to me recently with a volunteer last week. Her fingerprints were done but then her application went away. I had never noticed that before and I reached out to NetStudy, they told me it was because they did not complete the consent and disclosure piece for their application and I need to restart the process. I am assuming this is what happened with these staff?" On March 31, 2025, at 2:40 p.m., licensed assisted living director (LALD)-C stated all four staff were currently employed. Although requested, as of March 31, 2025, at 4:15 p.m., the licensee had not provided the surveyor with the staffing schedule. On March 31, 2025, at 4:18 p.m., receptionist (R)-J stated both DCI-H and DCI-I worked today, however they were no longer at the facility. R-J stated they did not have access to the staff schedule. The licensee's Background Investigation Policy, dated July 1, 2022, indicated, "Each individual who has been interviewed for employment must complete an employment application and	01290			

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01290	Continued From page 62 corresponding authorization and release for conducting a background investigation. Applicants who are offered employment will be contingent on the satisfactory results of a background investigation and the negative results of a pre-employment drug screen." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01350 SS=I	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure contracted staff met all requirements for training and competency evaluation, as identified in 144G.60, Subd. 4 and 144G.61 Subd 1. and 2, for two of two unlicensed personnel (ULP-K and ULP-M). This had the potential to affect all residents receiving medication and treatment services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).	01350			

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01350	Continued From page 63 The findings include: During entrance conference on March 31, 2025, at 9:45 a.m., associate executive director (AED)-D stated, ""We are using contract staff currently, we have one working tonight and another working tomorrow morning." On March 31, 2025, at 1:54 p.m., surveyor requested employee files for ULP-K and ULP-M. On March 31, 2025, at 2:50 p.m., AED-D stated ULP-K and ULP-M have not previously worked for the licensee and they would be trained at the beginning of their shift. On April 1, 2025, at 6:11 a.m., surveyor observed ULP-K working for the licensee. Surveyor asked ULP-K what training was provided at beginning of the shift and ULP-K stated, "[ULP-N] met with me and gave me a tour and showed me around and asked me about handwashing." ULP-K stated she did not have to do any paperwork and there was no other training given prior to preforming cares and helping with medications. On April 1, 2025, at 6:19 a.m., ULP-N stated, "I was unable to completely train her but I was able to check on what all she knows, I asked her about what cares she has done and she really knows her stuff, like she already told me she knew how to change the leg bag, so I verified she knew how before I let her do it, the only thing she didn't know was how to pass meds, she said she wasn't comfortable passing meds, so I only asked her to pass one medication, but I put the medication in the cup and had her pass it to the lady (an unidentified resident)."	01350			

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01350	Continued From page 64 On April 1, 2025, at 6:35 a.m., surveyor observed ULP-M provide toileting, perineal (peri) care, dressing, and morning (AM) cares to R7. On April 1, 2025, at 6:51 a.m., ULP-M stated, "This is my first day and I have not gotten any training except this piece of paper right here (paper had 5 room numbers that ULP was to do cares on) I have not had any other training except I was shown where the break room was." ULP-M asked ULP-O what cares she needed to do for the five residents as she did not have access to charting. On April 1, 2025, at 6:57 a.m., ULP-M stated, "This is my first day here, usually when I go someplace new, they usually give me some type of orientation, but I have not been shown anything here other than the break room. I don't even know if people are a one or two person assist, I am just rolling with the punches." On April 1, 2025, at 6:58 a.m., surveyor observed ULP-M transfer R8 as a one assist with a gait belt and a one assist with an EZ stand lift and a standby assist with no gait belt, while providing AM cares, toileting, dressing, peri care, and transfers. R8's records indicate she is a full two assist for all transfers. On April 1, 2025, at 8:50 a.m., AED-D stated, "This is the packet from last night for [ULP-K]. Orientation was done verbally, and nothing was signed off on, it was done by [ULP-N] and in her words she knows her stuff. And this morning there was miscommunication because they thought [licensed practical nurse LPN-A] was going to be here and it was not communicated to [LPN-A] that she needed training, so she has had no training. Also, since she [ULP-M] is only doing	01350			

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01350	Continued From page 65 cares so she does not have access to charting." When asked so who is charting the cares, and delegated tasks that she is doing AED-D answered, "I'm not sure." When asked about ULP-K's access to charting AED-D stated she also would not have access to charting because she only did cares. AED-D was informed that ULP-K also passed medications to one unidentified resident and AED-D stated, "She passed meds? Oh my God! Okay I will look into who she passed meds for and who charted it because she did not have access to the charting system to chart anything." On April 1, 2025, at 11:20 a.m. licensed assisted living director (LALD)-C stated, "The agency staff should not have been passing medications last night and I am not sure why they were, but they should not have been. So, I have no documentation for you because they are not in our system to document so they couldn't document that they passed medications." On April 1, 2025, at 4:01 p.m. surveyor requested the staff training policy, and no policy was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01350			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition	01370			

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01370	Continued From page 66 to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for	01370			

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01370	Continued From page 67 four of four unlicensed personnel ((ULP)-Q, ULP-R, ULP-T and ULP-U). 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: ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct care services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-Q's employee record lacked the following required trainings and competency evaluations: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; - training on the prevention of falls for providers	01370			

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01370	Continued From page 68 working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that included preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. ULP-R ULP-R had a hire date of May 7, 2024, and provided direct care services to residents. ULP-R's employee record lacked the following required trainings and competency evaluations: - reports of changes in the resident's condition to the supervisor; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety,	01370			

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01370	Continued From page 69 and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that included preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-T's employee record lacked the following required trainings and competency evaluations: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional;	01370			

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01370	Continued From page 70 - communication skills that included preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-U's employee record included training in the following areas, however, lacked the required competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; and - standby assistance techniques and how to perform them. ULP-U's employee record lacked the following required training: - communication skills that included preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and	01370			

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01370	Continued From page 71 - awareness of commonly used health technology equipment and assistive devices. On April 3, 2025, at 8:30 a.m., associate executive director AED-E stated, ""Everything we have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." The licensee's 5.02 Competency Training Evaluations policy, revised February 28, 2024, indicated when a registered nurse or licensed health professional staff of [licensee] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380			

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
(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
01380	Continued From page 72 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for four of four unlicensed personnel ((ULP)-Q, ULP-R, ULP-T and ULP-U). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	01380			

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01380	Continued From page 73 ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct care services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-Q's employee record lacked documentation of the following training and competency evaluations: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. ULP-R ULP-R had a hire date of May 7, 2024, and provided direct care services to residents. ULP-R's employee record lacked documentation of the following training and competency evaluations: -observing, reporting, and documenting resident status; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as	01380			

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01380	Continued From page 74 required. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-T's employee record lacked documentation of the following training and competency evaluations: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-U's employee record included training in the following areas, however, lacked the required competency evaluations: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On April 3, 2025, at 8:30 a.m., associate executive director AED-E stated, "Everything we	01380			

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01380	Continued From page 75 have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." The licensee's 5.02 Competency Training Evaluations policy, revised February 28, 2024, indicated when a registered nurse or licensed health professional staff of [licensee] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01420 SS=I	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained	01420			

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01420	Continued From page 76 in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for seven of seven unlicensed personnel (ULP)-B, ULP-M, ULP-Q, ULP-R, ULP-S, ULP-T, ULP-U) who utilized full body mechanical lift (Hoyer) transfers and provided catheter cares. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents.	01420			

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01420	Continued From page 77 ULP-B's employee record lacked documentation to indicate ULP-B was trained and demonstrated competency for using the Hoyer and providing catheter cares. ULP-M April 1, 2025, was ULP-M's first day working with the licensee. ULP-M was an agency employee that was contracted to provide direct services to residents. On April 1, 2025, at 6:58 a.m., surveyor observed ULP-M assist R8 with a transfer from the wheelchair as a one assist using the EZ stand. On April 1, 2025, at 6:57 a.m., ULP-M stated, "This is my first day here, usually when I go someplace new they usually give me some type of orientation, but I have not been shown anything here other than the break room. I don't even know if people are a 1 or 2 person assist, I am just rolling with the punches." ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct care services to residents. ULP-Q's employee record lacked documentation to indicate ULP-Q was trained and demonstrated competency for using the Hoyer and providing catheter cares. On April 3, 2025, at 9:26 a.m., ULP-Q stated they had received training on catheter cares and how to use the hoier lift from other ULPs when they started working for the licensee. ULP-Q stated they used the hoier lift to assist R13 and that they had assisted R10 with catheter cares by emptying R10's catheter bag and changing R10's foley catheter to their leg bag in the morning.	01420			

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01420	Continued From page 78 ULP-R ULP-R had a hire date of May 7, 2024, and provided direct care services to residents. ULP-R's employee record lacked documentation to indicate ULP-R was trained and demonstrated competency for using the Hoyer and providing catheter cares. On April 3, 2025, between 1:01 p.m., and 1:10 p.m., the surveyor observed ULP-R empty R-10's overnight catheter bag and change R10's overnight bag to a leg bag. On April 3, 2025, at 9:52 a.m., ULP-R stated when they started working with the licensee, they were trained by the other ULPs working the floor. ULP-R stated they apply compression stockings for R14 and they empty the catheter bag for R10. ULP-R stated they had not changed R10's foley bag over to their leg bag. ULP-R stated another ULP had shown them how to do it but they "went so fast" ULP-R did not feel comfortable completing the task without more training. ULP-R stated they had the other ULP on the unit complete that task when it was assigned to them. At that time, ULP-S stated they would train ULP-R on how to change the foley bag over to the leg bag catheter for R10 sometime that day. ULP-R stated they did not have any training, competency, or direct supervision from a nurse for any tasks they had completed while working on the unit with residents. ULP-S ULP-S had a hire date of September 24, 2024, and provided direct care services to residents. On April 3, 2025, from 1:40 p.m. to 2:05 during	01420			

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01420	Continued From page 79 continuous observation, the surveyor observed ULP-S assist R13 with dressing and then transferring R13 from the bed to the Broda chair using a full mechanical lift. During the transfer ULP-S placed the hoyer sling under R13 with the part of the sling that should have been by R13's shoulders at their knees and the part that would have been under their knees at their shoulders. The other employee helping with the transfer noticed the sling had been placed incorrectly and intervened to place the sling correctly prior to the transfer. On April 3, 2025, at 9:47 a.m., ULP-S stated they had worked with catheters and hoyer lifts in the past and were comfortable with those tasks when they started working with the licensee. ULP-S stated they knew they needed competency testing on catheter care from their previous experience and had asked Interim Clinical Nurse Supervisor/ Regional Clinical RN (ICNS)-D to observe them completing that task when they completed their medication administration competency. ULP-S stated they had not received training or competency testing from the licensee on working with the hoyer lift. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-T's employee record lacked documentation to indicate ULP-T was trained and demonstrated competency for using the Hoyer and providing catheter cares. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents.	01420			

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01420	Continued From page 80 ULP-U's employee record lacked documentation to indicate ULP-U was trained and demonstrated competency for using the Hoyer and providing catheter cares. On March 31, 2025, at 9:37 a.m., licensed assisted living director (LALD)-C stated they were aware there were ULPs training other ULPs on delegated tasks and that there were ULPs that had not been competency tested by a RN. The licensee's 6.14 Delegation of Assisted Living Services policy, dated February 28, 2024, indicated when the RN delegated tasks to the ULP, the RN was responsible to ensure the ULP had been appropriately trained in the proper methods to perform the tasks for each resident and that ULP had demonstrated the ability to competently follow the procedures and perform the tasks, prior to delegating the task. In addition, the RN would document specific instructions for the delegated tasks in the resident's record. The policy indicated an RN may delegate nursing services to a ULP who had successfully completed orientation, who had been trained in the service to be provided, and who had demonstrated to the RN the ability to competently follow the procedures for the resident. The policy listed some of the delegated tasks that would be included. The list included catheter care and the use of mechanical lifts. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01420			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440			

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01440	Continued From page 81 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for five of five employees (unlicensed personnel (ULP)-B, ULP-Q, ULP-R, ULP-T and ULP-U). 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	01440			

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01440	Continued From page 82 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents. ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct care services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-R ULP-R had a hire date of May 7, 2024, and provided direct care services to residents. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-B, ULP-Q, ULP-R, ULP-T, and ULP-U's records did not contain any documentation of supervision, therefore lacked evidence a RN conducted direct supervision of any of these ULPs within 30 days of performing delegated tasks, as required. On April 3, 2025, at 2:20 p.m., interim clinical nurse supervisor (ICNS)-D stated, "They (30 day supervisions) weren't being done, and that is	01440			

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01440	Continued From page 83 something that I had identified, so we will be working to correct that." The licensee's 4.05 Employee Records policy did not address 30-day supervision requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation	01460			

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01460	Continued From page 84 was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to 144G licensing requirements for two of five employees (unlicensed personnel (ULP)-Q and ULP-T) with employee records reviewed. 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: ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct care services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-Q employee record lacked evidence ULP-Q	01460			

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311			
(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
01460	Continued From page 85 received orientation to the following required topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; and -Principles of person-centered planning/service delivery. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-T employee record lacked evidence ULP-T received orientation to the following required topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; and -Principles of person-centered planning/service delivery. On April 3, 2025, at 8:30 a.m., associate executive director AED-E stated, ""Everything we have on the employee's is in their records we	01460			

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01460	Continued From page 86 gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, revised February 28, 2024, indicated "All staff of [licensee]providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	01470			

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01470	Continued From page 87 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01470			

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01470	Continued From page 88 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for two of five employees (unlicensed personnel (ULP)- B, and ULP-U). 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: ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents. ULP-B's employee record lacked the following required orientation content: - the principles of person-centered planning and service delivery. ULP-U	01470			

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01470	Continued From page 89 ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-U's employee record lacked the following required orientation content: - handling of emergencies and use of emergency services and - the principles of person-centered planning and service delivery. On April 3, 2025, at 8:30 a.m., associate executive director AED-E stated, "Everything we have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, revised February 28, 2024, indicated "1. All [licensee] employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. 2. The materials and/or type of training (i.e. video, lecture, reading, etc.) will be documented for compliance. 3. The orientation must contain the following topics: - An overview of the appropriate Assisted Living	01470			

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01470	Continued From page 90 statutes and rules - An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - Handling of emergencies and use of emergency services - Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services - A review of the types of assisted living services the employee will be providing and the facility's category of licensure - The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed - The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services - The identification of incidents of maltreatment	01470			

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01470	Continued From page 91 as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff received dementia training in the required areas for five of five employees (unlicensed personnel (ULP)-B, ULP-Q, ULP-R, ULP-T and ULP-U). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B had a hire date of October 24, 2023, and	01490			

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01490	Continued From page 92 provided direct care services to residents. ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-R ULP-R had a hire date of May 7, 2024, and provided direct care services to residents. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-B, ULP-Q, ULP-R, ULP-T, and ULP-U's employee files lacked evidence of completing dementia care training in the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On April 3, 2025, at 8:30 a.m., associate executive director AED-E stated, "Everything we have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything	01490			

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01490	Continued From page 93 that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." On April 3, 2025, at 4:34 p.m., ICNS-D stated, "They should have that training we do the dementia training, I'm not sure why they wouldn't have the full eight hours, at [a sister campus in another state] it's a whole day of training. (no other records were given to surveyors)." The licensee's 5.03 Dementia Training policy, revised February 28, 2024, indicated all staff of [licensee] are required to complete dementia training at the time of hire and annually thereafter. Furthermore, the required dementia training topics include an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors, communication skills, and person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another	01500			

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01500	Continued From page 94 source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01500			

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01500	Continued From page 95 and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees that performed direct services completed all required training components for each twelve months of employment for two of two employees (unlicensed personnel (ULP)-B and ULP-U). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents. ULP-B's employee record lacked annual training for the following required topics for 2024: - reporting of maltreatment of vulnerable adults;	01500			

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01500	Continued From page 96 - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques; - effective approaches to use in problem solving and communication; - review of provider policies and procedures; and - the principles of person-centered planning and service delivery. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-U's employee record lacked annual training for the following required topics that was due to be completed by the end of February 2025: - reporting of maltreatment of vulnerable adults; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques; - effective approaches to use in problem solving and communication; - review of provider policies and procedures; and - the principles of person-centered planning and service delivery. On April 3, 2025, at 8:30 a.m., associate executive director AED-E stated, ""Everything we have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have."	01500			

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01500	Continued From page 97 On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." The licensee's 5.06 Annual Required Staff Training policy, revised February 28, 2024, indicated "All staff that perform direct care services at [licensee] will complete at least eight hours of annual training for each 12 months of employment." In addition, the policy indicated the above topics were part of required annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two	01540			

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01540	Continued From page 98 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for five of five employees unlicensed personnel (ULP)-B, ULP-Q, ULP-R, ULP-T and ULP-U), with employee records reviewed. 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 had a current Assisted Living Facility with Dementia Care (ALFDC) license effective July 1, 2024, through June 30, 2025. ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents. ULP-B's employee record lacked the required full eight hours of initial dementia care training within 80 hours of the start date for providing direct care to residents. ULP-B's employee record lacked the required two hours of annual dementia training for 2024.	01540			

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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
01540	Continued From page 99 ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-Q's employee record included a certificate for four hours of dementia training completed on December 10, 2024, however, lacked the required full eight hours of initial dementia care training within 80 hours of the start date for providing direct care to residents. ULP-R ULP-R had a hire date of May 7, 2024, and provided direct care services to residents. ULP-R's employee record lacked the required full eight hours of initial dementia care training within 80 hours of the start date for providing direct care to residents. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-T's employee record included a certificate for four hours of dementia training completed on December 10, 2024, however, lacked the required full eight hours of initial dementia care training within 80 hours of the start date for providing direct care to residents. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents.	01540			

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01540	Continued From page 100 ULP-U's employee record lacked the required full eight hours of initial dementia care training within 80 hours of the start date for providing direct care to residents. ULP-U's employee record lacked the required two hours of annual dementia training due to be completed in February 2025. On April 3, 2025, at 8:30 a.m., associate executive director AED-E stated, "Everything we have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." On April 3, 2025, at 4:34 p.m., ICNS-D stated, "They should have that training we do the dementia training, I'm not sure why they wouldn't have the full eight hours, at [a sister campus in another state] it's a whole day of training. (no other records were given to surveyors)." The licensee's 5.03 Dementia Training policy, revised February 28, 2024, indicated direct care employees will complete eight hours of initial training within 80 hours of the employment start date and all staff will complete two hours of additional training for each 12 months of work	01540			

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01540	Continued From page 101 thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540			
01610 SS=D	144G.70 Subd. 2 (a-b) 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of five residents (R8) on or before the admission date. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01610			

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01610	Continued From page 102 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: R8 was admitted to the licensee on June 15, 2024. R8 had diagnoses to include chronic kidney disease, depression, major depressive disorder, type 2 diabetes mellitus. R8's unsigned Service Agreement dated January 15, 2025, indicated R8 received assistance with ambulation and mobility, transferring, medication management, bathing, grooming, dressing, meals, and toileting. R8's record included an unsigned pre-assessment opened June 20, 2024, a 14-day unsigned assessment opened July 3, 2024, comprehensive 90-day assessments unsigned and opened October 2, 2024, and January 8, 2025, and an unsigned change of condition assessment opened January 15, 2025, indicating 293 days had passed since admission without a completed signed assessment. On April 2, 2025, at 11:40 a.m., interim clinical nurse supervisor (ICNS)-D stated, "This (lack of signed assessments) is a deficiency that we know about, I have been working on getting this fixed for over a year, it is widespread." The licensee's 6.01 Assessments, Reviews &	01610			

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01610	Continued From page 103 Monitoring policy, revised February 28, 2024, indicated "[licensee] will 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." In addition, the policy indicated, "The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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	01620			

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01620	Continued From page 104 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) 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) conducted a comprehensive re-assessment following a change of condition for one of one resident (R8). In addition, the licensee failed to ensure the RN conducted ongoing nursing assessments not to exceed every 90-days for four of five residents (R5, R6, R8, and R10). 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: CHANGE OF CONDITION R8 R8 was admitted to the licensee on June 15, 2024. R8 had diagnoses to include chronic kidney disease, depression, major depressive disorder,	01620			

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01620	Continued From page 105 type 2 diabetes mellitus. R8's unsigned Service Agreement dated January 15, 2025, indicated R8 received assistance with ambulation and mobility, transferring, medication management, bathing, grooming, dressing, meals, and toileting. R8's record included an unsigned comprehensive assessment opened on January 15, 2025. On March 4, 2025, R8 was admitted to hospice. R8's record lacked a change of condition assessment. ONGOING ASSESSMENTS R5 R5 was admitted to the licensee on February 15, 2019. R5 had diagnoses to include cerebrovascular accident (stroke) and chronic obstructive pulmonary disease (lungs inability to circulate air). R5's unsigned Service Agreement dated October 26, 2023, indicated R5 received medication management, bathing, toileting, meals, and compression stockings. R5's record included unsigned comprehensive assessments opened on June 28, 2024, September 27, 2024, and December 26, 2024. All of R5's assessments were left uncompleted and without a signature from the nurse responsible for the assessment. As of April 4, 2025, R5's record indicated 99 days had passed since the last comprehensive assessment was opened. R6 R6 was admitted to the licensee on September 1, 2025.	01620			

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01620	Continued From page 106 R6 had diagnoses to include osteomyelitis (bone infection), atrial fibrillation, depression, diabetes, and hypertension. R6's unsigned service plan dated March 29, 2025, indicated R6 received medication management, housekeeping, and laundry services. R6's record included unsigned comprehensive assessments opened on August 15, 2024, September 13, 2024, and December 13, 2024. All of R6's assessments were left uncompleted and without a signature from the nurse responsible for the assessment. As of April 4, 2025, R6's record indicated 112 days had passed since the last comprehensive assessment was opened. R8's record included several unsigned comprehensive assessments opened on October 2, 2024, January 8, 2025, and January 15, 2025. All of R8's assessments were left uncompleted and without a signature from the nurse responsible for the assessment, indicating as of April 4, 2025, 184 days had passed without having a completed assessment since R10 started receiving services from licensee. R10 R10 was admitted to the licensee and began receiving assisted living services on October 29, 2024. R10's diagnoses included congestive heart failure, atrial fibrillation and hypertension. R10's signed Service Plan dated October 30, 2024, indicated R10 received assistance with medication administration, bathing, grooming, dressing, catheter cares, and toileting.	01620			

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01620	Continued From page 107 R10's record included several unsigned comprehensive assessments opened on October 30, 2024, November 13, 2024, and February 10, 2025. All of R10's assessments were left uncompleted and without a signature from the nurse responsible for the assessment, indicating as of April 4, 2025, 157 days had passed without having a completed assessment since R10 started receiving services from licensee. On April 2, 2025, at 11:40 a.m., interim clinical nurse supervisor (ICNS)-D stated, "This (lack of signed assessments) is a deficiency that we know about, I have been working on getting this fixed for over a year, it is widespread. It's the same thing with the service plans, they are supposed to be signed, and we are working to get that issue fixed going forward." The licensee's 6.01 Assessments, Reviews & Monitoring policy, revised February 28, 2024, indicated "Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." In addition, the policy indicated the assessment based on change of need for the resident be conducted in person, be in writing, and be dated and signed by the registered nurse who conducted the individualized review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			

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01640	Continued From page 108	01640			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for four of five residents (R5, R7, R8, and R13). 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	01640			

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01640	Continued From page 109 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: R5 R5 was admitted to the licensee on February 15, 2019. R5 had diagnoses to include cerebrovascular accident (stroke) and chronic obstructive pulmonary disease (lungs inability to circulate air). R5's unsigned Service Agreement dated October 26, 2023, indicated R5 received medication management, bathing, toileting, meals, and compression stockings. R7 R7 was admitted to the licensee on February 24, 2025. R7 had diagnoses to include memory impairment. On April 4, 2025, at 8:28 a.m., via email, interim clinical nurse supervisor (ICNS)-D sent an email that read, "I am unable to locate a service plan for [R7]." R8 R8 was admitted to the licensee on June 15, 2024. R8 had diagnoses to include chronic kidney disease, depression, major depressive disorder, type 2 diabetes mellitus.	01640			

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01640	Continued From page 110 R8's unsigned Service Agreement dated January 15, 2025, indicated R8 received assistance with ambulation and mobility, transferring, medication management, bathing, grooming, dressing, meals, and toileting. R13 R13 was admitted to the licensee on April 29, 2021, and began receiving assisted living services on August 1, 2021. R13's diagnoses included memory impairment, hypertension and cellulitis. R13's unsigned and undated Service Plan indicated R13 was receiving assistance with bathing, toileting, transfers using a full mechanical lift, assistance with eating, medication administration, laundry, and housekeeping. R5, R7, R8, and R13's current service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On April 2, 2025, at 11:40 a.m., ICNS-D stated, "This (lack of signed assessments) is a deficiency that we know about, I have been working on getting this fixed for over a year, it is widespread. It's the same thing with the service plans, they are supposed to be signed, and we are working to get that issue fixed going forward." The licensee's 2.38 Resident Record- Information and Content policy, revised February 28, 2024, indicated the resident record must include the facility's current and previous assessments and service plans.	01640			

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01640	Continued From page 111 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility 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	01730			

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01730	Continued From page 112 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 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of five residents (R8 and R10). 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: R8 R8 was admitted to the licensee on June 15, 2024. R8 had diagnoses to include chronic kidney disease, depression, major depressive disorder, type 2 diabetes mellitus. R8's unsigned Service Agreement dated January	01730			

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01730	Continued From page 113 15, 2025, indicated R8 received assistance with ambulation and mobility, transferring, medication management, bathing, grooming, dressing, meals, and toileting. R10 R10 was admitted to the licensee and began receiving assisted living services on October 29, 2024. R10's diagnoses included congestive heart failure, atrial fibrillation and hypertension. R10's signed Service Plan dated October 30, 2024, indicated R10 received assistance with medication administration, bathing, grooming, dressing, catheter cares, and toileting. R8 and R10's undated and unsigned comprehensive assessment that included an individualized medication management plan, lacked a description of identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis as well as procedures for staff to notify an RN when problems arose. On April 2, 2025, at 11:45 a.m., interim clinical nurse supervisor, (ICNS)-D stated, "We know there are some items missing that we need to get added, some of the residents have a separate sheet that identifies the missing items, but we are trying to get it done for everyone." The licensee's 7.03 Medication and Treatment policy dated February 28, 2024, indicated the licensee would prepare and include in the service plan a written statement of the medication management services that will be provided to the resident.	01730			

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311			
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01730	Continued From page 114 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for one of one resident (R9). 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	01760			

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01760	Continued From page 115 situation has occurred only occasionally). The findings include: On April 2, 2025, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-W prepare scheduled morning medications for R9. Next ULP-W put on gloves, set out a medication cup and opened R9's Diclofenac (pain relief) gel. The surveyor intervened and inquired about ULP-W's plan to measure the prescribed amount of gel. ULP-W then took the measuring ruler out of the box and measured the prescribed dose and verbalized four grams (gm) had been dispensed and placed into the medication cup for administration to R9. On April 2, 2025, at 8:32 a.m., ULP-W stated, "I use that (measuring ruler) on [unsecured assisted living] but not always over here in memory care." On April 2, 2025, at 2:53 p.m., interim clinical nurse supervisor (ICNS)-D stated, "Staff complete the medication training and competency sign off for all methods and should follow the procedure all of the time, not just in one area." The licensee's 7.15 Medication & Treatment-Administration & Delegation policy, revised February 28, 2024, indicated "When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee] will ensure that the registered nurse has: 1. Instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for	01760			

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01760	Continued From page 116 each resident and documented those instructions in the resident's records 3. Communicated with the unlicensed personnel about the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are	01790			

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01790	Continued From page 117 prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse	01790			

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01790	Continued From page 118 was not available for three of three employees (ULP-B, ULP-Q, and ULP-U). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents. ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-B, ULP-Q, and ULP-U's employee records lacked documentation of training and competencies for unplanned time away when the RN was not available On April 3, 2025, at 8:30 a.m., associate executive director AED-D stated, "Everything we have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical	01790			

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01790	Continued From page 119 nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." The licensee's 7.10 Medication Management-Planned & Unplanned Time Away policy, revised February 28, 2024, indicated, "For unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: 1. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. 2. The registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: a. the type of container or containers to be used for the medications appropriate to the provider's medication system b. how the container or containers must be labeled c. the written information about the medications to be given to the resident or resident's representative d. how the unlicensed staff must document in the resident's record that medications have been given to the resident or the resident's	01790			

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01790	Continued From page 120 representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information. e. how the registered nurse shall be notified that medications have been given to the resident or resident's representative and whether the registered nurse needs to be contacted before the medications are given to the resident or the resident's representative f. a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel g. how the unlicensed staff must document in the resident's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate.	01810			

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01810	Continued From page 121 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over the counter (OTC) drugs were stored as appropriate for one of one resident (R5). 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: R5 was admitted to the licensee on February 15, 2019, and began receiving assisted living services on August 1, 2021. R5's diagnoses included cerebrovascular accident (stroke) and chronic obstructive pulmonary disease (COPD). R5's unsigned assessment dated December 26, 2024, indicated the licensee would store R5's medications in a central medication storage location. On April 1, 2025, at 7:12 a.m., the surveyor observed open bottles of Melatonin 10 milligrams (mg), Tylenol Arthritis 650 mg, and an open box of Imodium A-D 2 mg on resident's counter. Unlicensed personnel (ULP)-B stated they didn't know R5 had OTC medications in the apartment and facility staff administer all medications except R5's creams.	01810			

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01810	Continued From page 122 On April 1, 2025, at 7:14 a.m., ULP-B stated upon hire, training last approximately two weeks and finished when a registered nurse (RN) signed off on medication competencies. R5's medication administration record (MAR) dated April 1, 2025, through April 30, 2025, indicated none of the above medications was currently ordered for R5. On April 2, 2025, at 2:47 p.m., interim clinical nurse supervisor (ICNS)-D stated, "We require prescriptions for all medications the resident takes. We take an all or none stance in terms of if we manage the meds or the resident manages the medications. Staff should alert a nurse if there are OTC meds in a resident apartment so the nurse can investigate those situations. No medications should be stored in residents' rooms unless there is an order for self-administer." The licensee's 7.11 Medication Storage policy, revised February 28, 2024, indicated, "medications will be stored consistent with each residents' medication management plan and service plan" and "medications managed by [licensee] will be stored to prevent diversion of medications by residents or others who may have access to the medications." The licensee's 7.12 Medications- Prescribed, Not Prescribed & OTC, revised February 28, 2024, indicated, "[licensee] will determine whether the facility shall require a prescription for all medications the provider manages. The facility will inform the resident whether the facility requires a prescription for all OTC and dietary supplements before the facility agrees to manage those medications."	01810			

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01810	Continued From page 123 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R5). 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: R5 admitted to the licensee and began receiving services on October 26, 2023. R5 had diagnoses to include cerebrovascular accident (stroke) and chronic obstructive pulmonary disease (COPD).	01820			

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01820	Continued From page 124 R5's unsigned Service Plan Detail dated September 27, 2024, indicated R5 received assistance with oxygen, medication management, bathing, activities of daily living reminder and set-up, denture care, and compression stocking application and removal. R5's Medication Administration Record (MAR) dated April 1, 2025, through April 30, 2025, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that R5 received Reguloid (stool softener) 0.52 grams (gm) take two capsules by mouth daily. R5's record lacked a signed order for Reguloid 0.52 grams (gm) take two capsules by mouth daily. On April 3, 2025, at 8:54 a.m., interim clinical nurse supervisor (ICNS)-D stated, "That order is not in her chart and I'm not sure why because her provider has seen her and looked at her medications. I will contact her provider today to review the medication and get an order to continue the med or discontinue." The licensee's 7.20 Medication & Treatment Orders policy, revised February 28, 2024, indicated "the registered nurse (RN) is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records; b. communicated to the resident or responsible party; c. educate resident or responsible party on all medication and treatment orders; and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff." As well as, "an order for medication or treatment must	01820			

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01820	Continued From page 125 contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of four residents (R5). 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: R5 admitted to the licensee and began receiving services on October 26, 2023.	01830			

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01830	Continued From page 126 R5 had diagnoses to include cerebrovascular accident (stroke) and chronic obstructive pulmonary disease (COPD). R5's unsigned Service Plan Detail dated September 27, 2024, indicated R5 received assistance with oxygen, medication management, bathing, activities of daily living reminder and set-up, denture care, and compression stocking application and removal. R5's most recent provider order for Ciclopirox 8 percent (%) solution- apply to all toenails and adjacent skin daily, was signed on April 12, 2023. On April 3, 2025, at 8:54 a.m., interim clinical nurse supervisor (ICNS)-D stated, "Orders need to be resigned each year. I am unsure why this medication was not on her order summary that the provider reviewed and signed. I will request a new prescription." The licensee's 7.20 Medication & Treatment Orders policy, revised February 28, 2024, indicated the licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880			

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01880	Continued From page 127 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications according to manufacturer's instructions when they failed to monitor the temperature of the secured unit medication refrigerator. This had the potential to affect all residents with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 1, 2025, at 2:02 p.m., the surveyor requested to see the secured unit refrigerator designated for medication storage. The refrigerator was in a locked storage room next to the main level nursing office. Unlicensed personnel (ULP)-V unlocked the medication refrigerator. The medication refrigerator had a thermometer placed inside that always displayed the current temperature of the refrigerator interior. The thermometer was analog and did not have the capability to be connected to any monitoring technology. The contents of the medication refrigerator included: - R17's five Lantus Solostar 100 units per milliliter	01880			

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
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01880	Continued From page 128 (ml) injectable pens; - R18's four bisacodyl suppositories 10 milligrams (mg); and - R19's sealed bottle of dorzol/timol 2 percent (%) - 0.5% solution. Lantus Solostar manufacturer instructions, dated August 2022, indicated unopened Lantus Solostar injection pens should be stored in their original outer packaging under refrigeration between thirty-six- and forty-six-degrees Fahrenheit. After the injection pens were used, they should be stored at room temperature for up to twenty-eight days. Bisacodyl suppository drug label dated October 17, 2024, indicated the suppositories should be stored at 68-77 degrees Fahrenheit (F). On April 1, 2025, at 2:07 p.m., the surveyor observed a document titled Daily Refrigerator/ Freezer/ Storage Room Temperature Log on a clipboard on top of the refrigerator. The document was dated January without a year noted and included four columns. The first column was titled date, and each box of the column contained a number, the numbers were 1 through 31 for each day of the month. The second column indicated it was for the time the temperature was observed. The third column was for the medication refrigerator temperature to be recorded. The fourth column read it was for the "food service worker's initials". The documentation area of the temperature log included two entries. One entry on the line for January 20 indicated the refrigerator temperature was 40 degrees and one entry on the line for January 28 indicated the refrigerator temperature was 42 degrees. There were no other papers on the clipboard or in the surrounding area for current or other previous	01880			

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01880	Continued From page 129 months. On April 2, 2025, at 11:34 a.m., interim clinical nurse supervisor (ICNS)-D stated the medication refrigerator temperature should be checked and recorded daily. ICNS-D stated they were not aware who the temperature monitoring had been assigned to or where the past logs were filed. ICNS-D verified there was no direction on the temperature log about what to do with the temperature reading, what numbers were out of the normal range, and who to report them to. The licensee's 7.11 Medication Storage policy, dated February 28, 2024, indicated medications would you stored per manufactures instructions and only authorized staff would have to access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	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 ensure time sensitive medications were dated when opened	01890			

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01890	Continued From page 130 for four of four residents (R24, R25, R26, and R28) with time sensitive medications. In addition, the licensee failed to ensure to discard expired medication were removed from five out of five medication carts observed. 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: TIME SENSITIVE MEDICATION On April 1, 2025, at 1:39 p.m. surveyor observed the upper-level secured unit medication carts labeled Moose and Deer, and observed the following medications opened with no open date. - R24's Nyamyc powder 100,000 units/gram, (used to treat fungal infections) with an unknown amount of medication left in the bottle. The instructions read apply topically twice a day. There was no open date on the bottle. - R25's Nystop powder 100,000 units/gram, with an unknown amount of medication left in the bottle. The instructions read apply to rash twice a day until healed. There was no open date on the bottle. On April 1, 2025, at 4:11 p.m. surveyor observed the two unlabeled assisted living third floor medication carts and observed the following medications opened with no open date.	01890			

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01890	Continued From page 131 R26's Humulin 70-30 u (unit)/ml (milliliter) injectable insulin pen with an unknown amount of medication left in the pen. There was no open date on the insulin pen. R26's latanoprost 0.005% (percent) solution, (used to treat glaucoma) with an unknown amount of medication left in the bottle. The instructions read instill one drop in both eyes every evening. There was no open date on the bottle. R28's Polyvinyl alcohol ophthalmic solution 1.4 % with an unknown amount of medication left in the bottle. The instructions read place one drop in both eyes in the morning. There was no open date on the bottle. EXPIRED MEDICATIONS On April 1, 2025, at 10:29 a.m., surveyor observed the main level secured unit medication cart labeled Bear and observed the following expired medications: - R20's melatonin 3 mg (milligram) tablets with an unknown number of tablets. The instructions read take one tablet by mouth every night at bedtime as needed (PRN) for insomnia. The medication expired on September 29, 2024. - R20's acetaminophen 500 mg tablets with an unknown number of tablets. The instructions read take two tablets by mouth twice daily as needed. The medication expired on December 12, 2024. - R21's acetaminophen 325 mg tablets with an unknown number of tablets. The instructions read take two tablets every four to six hours as needed for pain. The medication expired on December	01890			

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01890	Continued From page 132 10, 2024. - R22's senna 8.6 mg tablets with an unknown number of tablets. The instructions read take one tablet by mouth twice daily as needed for constipation. The medication expired on December 15, 2024. On April 1, 2025, at 1:29 p.m., surveyor observed the lower-level secured unit medication carts labeled Moose and Deer, and observed the following expired medications: - R23's tramadol hydrochloride 50 mg tablets with an unknown number of tablets. The instructions read take one tablet by mouth every six hours as needed for pain The medication expired on January 22, 2025. On April 1, 2025, at 4:48 p.m., surveyor asked about the lack of a date open on the insulin pen and unlicensed personnel (ULP)-B stated she was trained on insulin administration by the nurse when she started eight years ago though she did not recall any details about it. On April 2, 2025, at 4:18 p.m., interim clinical nurse supervisor (ICNS)-D stated, "When a medication is expired the staff are supposed to let the nurses know so we can dispose of the medication, but they don't always do that, so we need to start auditing the carts. Same with the date open stickers. When you open it, you should put the date on it. We will need to re-educate on that." The licensee's 7.23 Medication Disposal policy dated February 28, 2024, indicated expired medications managed by the licensee would be disposed of according to accepted practices of	01890			

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01890	Continued From page 133 the Minnesota board of Pharmacy and the labels form the containers be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition,	01910			

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01910	Continued From page 134 and names of staff and other individuals involved in the disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was discharged from the licensee on January 21, 2025. On April 1, 2025, R1's discharge record was provided by the licensee. R1's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On April 1, 2025, at 1:50 p.m., interim clinical nurse supervisor (ICNS)-D stated, "[R1] did not have a disposition completed and I do not know why. I would doubt if there was medication disposition for any discharges recently. There has not been a discharge since I started here. R1s discharge summary was lacking a lot of information, and I am not sure why because it was completed before I started here. My expectation would be a nurse completes a discharge, handles medications, and completes hand-off report to next facility."	01910			

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01910	Continued From page 135 The licensee's 7.23 Medication Disposal policy, revised February 28, 2024, indicated "Staff of [Licensee] will dispose any medication, as needed, in a proper way including following the guidelines of the Minnesota Board of Pharmacy. PROCEDURE: 1. Any current medications being managed by Rose Arbor and Wildflower must be provided to the resident when the resident's service plan ends, or medication management services are no longer part of the service plan. 2. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. 3. The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must	01940			

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01940	Continued From page 136 contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content and failed to include all treatments or therapies ordered for one of one resident (R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01940			

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01940	Continued From page 137 The findings include: R10 was admitted to the licensee and began receiving assisted living services on October 29, 2024. R10's diagnoses included congestive heart failure, atrial fibrillation and hypertension. R10's signed Service Plan dated October 30, 2024, indicated R10 received assistance with medication administration, bathing, grooming, dressing, catheter cares, and toileting. R10's Routine Treatment Order form, dated April 1, 2025, through April 30, 2025, indicated R10 had instructions for catheter cares to include change the catheter bag to the day bag in the morning and the night bag at bedtime. Rinse the used bag with warm water and hang it to dry in the bathroom of the residents as to be used the following day. Chart the result if this was done or not. R10's Routine Treatment Order form did not indicate any instructions for what staff should do for any catheter issues, or any signs and symptoms to update the nurse. R10's unsigned and undated comprehensive assessment which included evaluation of treatment and therapies lacked: - resident specific instructions related to the treatments/therapy administration; - process for notifying an RN or appropriate licensed health professional when an issue or concern arises; and - resident specific requirements related to documentation of treatments/therapy received, verification that it was administered as prescribed and monitoring to prevent possible complications and/or adverse reactions.	01940			

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01940	Continued From page 138 On April 3, 2025, at 4:38 p.m., interim clinical nurse supervisor (ICNS)-D stated, "I know not all the doctors give parameters and we have recognized that we are missing these and we are working to correct that." The licensee's 7.05 Treatment & Therapy Management Plan policy was requested multiple times throughout survey and was never provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and	01950			

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01950	Continued From page 139 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed and ensured competency of the unlicensed personnel (ULP) on proper treatment procedures, specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for one of one resident (R10) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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: R10 was admitted to the licensee and began receiving assisted living services on October 29, 2024. R10's diagnoses included congestive heart failure, atrial fibrillation and hypertension. R10's signed Service Plan dated October 30, 2024, indicated R10 received assistance with medication administration, bathing, grooming, dressing, catheter cares, and toileting. R10's Routine Treatment Order form, dated April 1, 2025, through April 30, 2025, indicated R10 had instructions for catheter cares to include change the catheter bag to the day bag in the	01950			

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01950	Continued From page 140 morning and the night bag at bedtime. Rinse the used bag with warm water and hang it to dry in the bathroom of the residents as to be used the following day. Chart the result if this was done or not. R10's Routine Treatment Order form did not indicate any instructions for what staff should do for any catheter issues, or any signs and symptoms to update the nurse. ULP-B ULP-B had a hire date of October 24, 2023, and provided direct care services to residents. ULP-B's employee record lacked any competency trainings completed by the RN. ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-Q's employee record lacked competencies for catheter care and compression stockings completed by the RN. ULP-R ULP-R had a hire date of May 7, 2024, and provided direct care services to residents. ULP-R's employee record lacked any competency trainings completed by the RN ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-T's employee record lacked any competency	01950			

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01950	Continued From page 141 trainings completed by the RN. ULP-U ULP-U had a hire date of February 19, 2024, and provided direct care services to residents. ULP-U's employee record lacked any competency trainings completed by the RN. On March 31, 2025, at 9:37 a.m., licensed assisted living director (LALD)-C stated they were aware there were ULPs training other ULPs on delegated tasks and that there were ULPs that had not been competency tested by a RN. On April 3, 2025, at 4:38 p.m., interim clinical nurse supervisor (ICNS)-D stated, "I know not all the doctors give parameters and we have recognized that we are missing these and we are working to correct that." The licensee's 7.05 Treatment & Therapy Management Plan policy was requested multiple times throughout survey and was never provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or	01970			

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01970	Continued From page 142 therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded treatment orders were maintained for one of one resident (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R8 R8 was admitted to the licensee on June 15, 2024. R8 had diagnoses to include chronic kidney disease, depression, major depressive disorder, type 2 diabetes mellitus. R8's unsigned Service Agreement dated January 15, 2025, indicated R8 received assistance with ambulation and mobility, transferring, medication management, bathing, grooming, dressing, meals, and toileting. On April 1, 2025, at 6:58 a.m., surveyor observed unlicensed personnel (ULP)-M assist R8 with toileting and dressing. R8's Routine Treatment Order form, dated April 1,	01970			

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01970	Continued From page 143 2025, through April 30, 2025, indicated R8 would have compression socks applied every morning and removed every evening. R8's signed provider orders dated June 18, 2024, lacked an order for compression stockings. On April 2, 2025, at 11:42 a.m., interim clinical nurse supervisor (ICNS)-D stated, "I am unsure why there are no signed treatment orders, this is something that can get missed for some of our residents when hospice takes over." The licensee's 7.20 Medication and Treatment Orders policy dated February 28, 2024, indicated a written prescriber's order must be obtained for any treatment provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040			

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02040	Continued From page 144 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 2, 2025, director of maintenance (DOM)-P provided an emergency preparedness binder and stated the hazard vulnerability assessment (HVA) was inside. The HVA inside the emergency preparedness binder did not include a section that identified hazards on and around the property and did not include mitigation strategies for any hazards or risks that were identified in the HVA. DOM-P left the facility before an interview could be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			

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02110	Continued From page 145	02110			
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110			

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02110	Continued From page 146 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents or the resident's legal and/or designated representative at the time of move-in for one of one residents (R13). 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: R13 was admitted to the licensee on April 29, 2021, and began receiving assisted living services on August 1, 2021. R13's resident records lacked evidence the licensee provided a resident or resident representative policies and procedures that addressed 144G.82 Subd. 3., at the time of move-in to the facility or upon conversion to assisted living licensure. On April 3, 2025, at 2:07 p.m., licensed assisted living director (LALD)-C stated the licensee had all required dementia care policies and procedures, however, did not provide dementia care policies and procedures to resident or resident's family members. LALD-C stated they were unaware of why residents did not receive or acknowledge receiving the required dementia	02110			

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02110	Continued From page 147 care policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02130 SS=F	144G.83 Subd. 2 Staffing requirements (a) The licensee must ensure that staff who provide support to residents with dementia can demonstrate a basic understanding and ability to apply dementia training to the residents' emotional and unique health care needs using person-centered planning delivery. Direct care dementia-trained staff and other staff must be trained on the topics identified during the expedited rulemaking process. These requirements are in addition to the licensing requirements for training. (b) Failure to comply with paragraph (a) or subdivision 1 shall result in a fine under section 144G.31. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff working in the dementia care unit were trained in person-centered care approach for two of three unlicensed personnel (ULP)-Q and ULP-T with records reviewed. 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	02130			

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02130	Continued From page 148 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 current Assisted Living Facility with Dementia Care (ALFDC) license effective July 1, 2024, through June 30, 2025. The licensee failed to ensure the dementia care unit was staffed with ULP who had been instructed in the person-centered care approach. ULP-Q ULP-Q had a hire date of December 4, 2024, and provided direct services to residents. On April 2, 2025, at 12:46 p.m., the surveyor observed ULP-Q prepare and administer medications for R16. ULP-T ULP-T had a hire date of December 19, 2024, and provided direct care services to residents. ULP-Q and ULP-T's employee records lacked evidence of completion of training in dementia care, including person-centered care approach. On April 3, 2025, at 8:30 a.m., associate executive director AED-D stated, ""Everything we have on the employee's is in their records we gave you, or we don't have it." On April 3, 2025, at 10:30 a.m., interim clinical nurse supervisor (ICNS)-D stated, "From a clinical standpoint we have sent you everything that you have requested. I will look again and see, because I know I did some of that training	02130			

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02130	Continued From page 149 and some of those assessments but otherwise yes, we have sent everything we have." On April 3, 2025, at 4:27 p.m., ICNS-D stated, "Why things are missing, well, it's a lack of auditing, lack of completion, and poor follow through." On April 3, 2025, at 4:34 p.m., ICNS-D stated, "They should have that training we do the dementia training, I'm not sure why they wouldn't have the full eight hours, at [a sister campus in another state] it's a whole day of training. (no other records were given to surveyors)." On April 3, 2025, at 4:39 p.m., ICNS-D stated, "That has been addressed time and time again, and that is not appropriate at all, and there is a need for community wide re-education." The licensee's 5.03 Dementia Training policy, revised February 28, 2024, indicated all staff of [licensee] are required to complete dementia training at the time of hire and annually thereafter. Furthermore, the required dementia training topics include person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02130			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the	02170			

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02170	Continued From page 150 following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written individualized activity evaluation that addressed all provisions for two of two residents (R10 and R13).	02170			

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02170	Continued From page 151 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: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective July 1, 2024, through June 30, 2025. R10 R10's diagnosis included congestive heart failure, atrial fibrillation and hypertension. R10's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R13 R13's diagnosis included memory impairment, hypertension and cellulitis. R13's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:	02170			

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02170	Continued From page 152 - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. On April 3, 2025, at 4:37 p.m., interim clinical nurse supervisor (ICNS)-D stated, "We do something in the 90-day (assessment) but if it's an actual activity assessment you're looking for, no, we will have to look into that." The licensee's 3.05 Assisted Living Dementia Care Enrichment Programs, Activities and Outdoor Space policy, revised February 28, 2024, indicated the licensee would attempt to provide valuable activities and life enrichment programs for residents and each resident must be evaluated for activities according to the licensing rules of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170			
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request.	02260			

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02260	Continued From page 153 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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 an assisted living with dementia care license, effective June 17, 2024. On April 3, 2025, at 10:41 a.m., after several requests, the surveyor was not provided licensee's dementia care and training program. Associate executive director AED-E stated the licensee had identified missing items and components needed to meet Minnesota requirements." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02260			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310			

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02310	Continued From page 154 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of five residents (R5 and R8) with consumer bed rails and assistive devices. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R5 R5 was admitted to the licensee on February 15, 2019. R5 had diagnoses to include cerebrovascular accident (stroke) and chronic obstructive pulmonary disease (lungs inability to circulate air). R5's unsigned Service Agreement dated October 26, 2023, indicated R5 received medication management, bathing, toileting, meals, and compression stockings.	02310			

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
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02310	Continued From page 155 On April 1, 2025, at 6:58 a.m., the surveyor observed R5's bed had bilateral hospital bed rails on the top half of the bed. The bed rails were firmly attached to the bed. R5 stated they used the bed rail for positioning in bed and getting in and out of bed. R5's record included an unsigned 90- day assessment that was opened December 26, 2024, that indicated R5 had no assisstive devices. R5's record lacked a bed rail assessment to include: -Documentation the bed rails were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rails for areas of entrapment, stability, and correct installation; and -Documentation of the risks versus benefits of bedrails. R8 R8 was admitted to the licensee on June 15, 2024. R8 had diagnoses to include chronic kidney disease, depression, major depressive disorder, type 2 diabetes mellitus with diabetic neuropathy. R8's unsigned Service Agreement dated January 15, 2025, indicated R8 received assistance with ambulation and mobility, transferring, medication management, bathing, grooming, dressing, meals, and toileting. On April 1, 2025, at 6:58 a.m., the surveyor observed R8's bed had bilateral Halo Safety Ring bed rails (consumer bed rails) located at the top	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311			
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02310	Continued From page 156 of the bed. The bed rail was firmly attached to the bed. R8 stated they used the bed rail for positioning in bed and for getting in and out of bed. R8's record included an unsigned change of condition assessment that was opened January 15, 2025, that indicated R8 had no assisstive devices. R8's record lacked a bed rail assessment to include: -Documentation the bed rails were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rails for areas of entrapment, stability, and correct installation; and -Documentation of the risks versus benefits of bedrails. On April 2, 2025, at 1:40 p.m., interim clinical nurse supervisor (ICNS)-D stated, ""I am not seeing it for [R8], I know we have an assessment we can do, but I am going to go ahead and say we never did it. So we are not going to have those." Surveyor asked if they would have bed rail assessments for any residents that have bedrails and ICNS-D stated, "I'm guessing not." The Food and Drug Administration (FDA) guidance A Guide to Bed Safety dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the	02310			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311			
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02310	Continued From page 157 best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." The MDH website indicated for consumer bed rails, the licensee must include in their documentation: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee ' s Policy for The Use of Side Rails	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2025
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02310	Continued From page 158 in Assisted Living, dated January 21, 2016, indicated, "The Community shall never encourage or bring about the use of side rails in the Community nor shall it provide a hospital bed for any Resident ' s use." The policy did not address the need for an assessment or addressing risks and benefits. TIME PERIOD FOR CORRECTION: Immediate	02310			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP)-N followed appropriate medication administration procedures. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	02320			

Minnesota Department of Health

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02320	Continued From page 159 During entrance conference on March 31, 2025, at 9:45 a.m., associate executive director (AED)-E stated, ""We are using contract staff currently, we have one working tonight and another working tomorrow morning." ULP-K had a hire date of March 31, 2025, and was working the overnight shift into April 1, 2025. ULP-K's record lacked documentation the employee had been trained and competency tested prior to being delegated medication administration. On March 31, 2025, at 1:54 p.m., surveyor requested employee files for ULP-K and ULP-M. On March 31, 2025, at 2:50 p.m., AED-E stated ULP-K and ULP-M have not previously worked for the licensee and they would be trained at the beginning of their shift. On April 1, 2025, at 6:11 a.m., ULP-K (an agency staff caregiver who had worked independently the overnight of March 31, 2025, into April 1, 2025) stated, "[ULP-N] met with me and gave me a tour and showed me around and asked me about handwashing." ULP-K stated she did not have to do any paperwork and there was no other training given prior to preforming cares and helping with medications. ULP-N was trained to pass medications and provide direct care services. On April 1, 2025, at 6:19 a.m., ULP-N stated she had trained in a new staff from an agency company (ULP-K) on the overnight shift from March 31, 2025, into April 1, 2025. ULP-N stated, "I was unable to completely train her but I was able to check on what all she knows, I asked her	02320			

Minnesota Department of Health

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02320	Continued From page 160 about what cares she has done and she really knows her stuff, like she already told me she knew how to change the leg bag, so I verified she knew how before I let her do it, the only thing she didn't know was how to pass meds, she said she wasn't comfortable passing meds, so I only asked her to pass one medication, but I put the medication in the cup and had her pass it to the lady." On April 1, 2025, at 8:50 a.m. surveyor asked associate executive director AED-E how ULP-K would have been able to chart medication administration without access to charting. AED-E stated, "She passed meds? Oh my God! Okay I will look into who she passed meds for and who charted it because she did not have access to the charting system to chart anything." On April 1, 2025, at 11:20 a.m., licensed assisted living director (LALD)-C stated, "The agency staff should not have been passing medications last night and I am not sure why they were, but they should not have been. So, I have no documentation for you because they are not in our system to document so they couldn't document that they passed medications." On April 3, 2025, at 6:40 a.m., ULP-N stated, "I let [ULP-K] pass meds for room 203 just to help her get comfortable. I charted for her because she wasn't supposed to be doing meds that night. I had to do her charting because she didn't have access to charting. Sometimes the agency staff have access to charting and then sometimes they don't. I don't really know how that works, but if they don't have access then we have to chart for them." The licensee's 7.15 Medication & Treatment -	02320			

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02320	Continued From page 161 Administration & Delegation policy, revised February 28, 2024, indicated, "Prior to a ULP providing delegated medication administration and/or treatments/therapy, the following must occur... 5. A RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident 's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. 6. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN. 7. Written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02350 SS=F	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with	02350			

Minnesota Department of Health

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02350	Continued From page 162 courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident (R7) was treated with courtesy, respect, dignity, and privacy when assisted with activities of daily living. 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: R7 R7 was admitted to the licensee and started receiving assisted living services on February 24, 2025. R7's diagnoses included memory impairment. On April 3, 2025, at 12:40 p.m., surveyor observed unlicensed personnel (ULP)-Q sitting on a chair next to the medication cart looking at her personal cell phone. There were six residents sitting in the dining room common area and one resident (R7) was standing in front of ULP-Q asking repeatedly, "Can you help me?" After R7 asked, "Can you help me?" four times, ULP-Q stood up abruptly and with a raised voice stated, "[R7], I already took you to the bathroom, I don't	02350			

Minnesota Department of Health

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02350	Continued From page 163 have the same parts as you so I can't teach you how to pee so go sit down." Surveyor walked up to ULP-Q and made sure she saw me in the area and asked if she would be getting up another resident soon ULP-Q stated, "I will but first I need to take [R7] to the bathroom." On April 3, 2025, at 4:39 p.m., ICNS-D stated, "That has been addressed time and time again, and that is not appropriate at all, and there is a need for community wide re-education." On April 4, 2025, via email interim clinical nurse supervisor (ICNS)-D indicated they were unable to locate a service plan for R7. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350			
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in	02410			

Minnesota Department of Health

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02410	Continued From page 164 the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for two of two residents (R10 and R13) observed during medication and treatment administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R10 R10 was admitted to the licensee and began receiving assisted living services on October 29, 2024. R10's diagnoses included congestive heart failure, atrial fibrillation and hypertension. R10's signed Service Plan dated October 30, 2024, indicated R10 received assistance with medication administration, bathing, grooming,	02410			

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02410	Continued From page 165 dressing, catheter cares, and toileting. On April 3, 2025, from 1:01 p.m., through 1:10 p.m., surveyor observed unlicensed personnel (ULP)-R enter R10's room and empty R10's catheter bag and change the overnight catheter bag to the leg bag. ULP-R did not close R10's door or provide privacy before or during these cares. R13 R13 was admitted to the licensee on April 29, 2021, and began receiving assisted living services on August 1, 2021. R13's diagnoses included memory impairment, hypertension and cellulitis. R13's unsigned and undated Service Plan indicated R13 was receiving assistance with bathing, toileting, transfers using a full mechanical lift, assistance with eating, medication administration, laundry, and housekeeping. On April 3, 2025, from 1:40 p.m., through 2:05 p.m., surveyor observed cares for R13. Surveyor entered R13's room where ULP-Q was feeding R13. ULP-Q stated they were waiting for ULP-S to assist with dressing and transferring. ULP-S entered R13's room and without shutting the door to provide privacy they assisted R13 with removing her blankets and dressing her lower half. Licensed practical Nurse (LPN)-A came in and stated, "I am here to watch, is it ok if I correct what they are doing wrong?" Then LPN-A instructed them to close the door for privacy. On April 3, 2025, at 4:41 p.m. interim clinical nurse supervisor (ICNS)-D stated, "Yes, we will need to do re-training and educated on that for	02410			

Minnesota Department of Health

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02410	Continued From page 166 everyone." The licensee's 5.02 Competency Training Evaluations policy, dated February 28, 2024, indicated the licensee training for ULP's would include awareness of confidentiality and privacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			
03090 SS=F	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	03090			

Minnesota Department of Health

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03090	Continued From page 167 or has the potential to affect a large portion or all of the residents). The findings include: On March 31, 2025, at 10:50 a.m., during a tour of the facility, a notice of electronic monitoring within the facility was not present at either the assisted living or memory care entrance. On April 3, 2025, at 5:17 p.m., licensed assisted living director (LALD)-C stated, "We don't have the electronic monitoring sign at the front because we have it above each of the resident rooms, so we don't need it at the front." The licensee's 2.15 Electronic Monitoring policy, revised February 28, 2024, indicated "[Licensee] will support the use of electronic monitoring by our residents and resident representatives (as defined in the law). PROCEDURE: 1. Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03090			



Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: 04/01/25
Time: 14:30:00
Report: 8087251083

Food and Beverage Establishment Inspection Report

Page 1

Location:

Rose Arbor/Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN55311
Hennepin County, 27

Establishment Info:

ID #: 0038661
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634935910
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air

Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR - DEER

Violation Issued: No

Process/Item: Cold Holding: MILK

Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR - DEER

Violation Issued: No

Process/Item: Cold Holding: CUT MELON

Temperature: 35 Degrees Fahrenheit - Location: REFRIGERATOR - DEER

Violation Issued: No

Process/Item: Ambient Air

Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR - BEAR

Violation Issued: No

Process/Item: Cold Holding: YOGURT

Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR - BEAR

Violation Issued: No

Process/Item: Cold Holding: CUT MELON

Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR - BEAR

Violation Issued: No

Process/Item: Ambient Air

Temperature: 32 Degrees Fahrenheit - Location: REFRIGERATOR - WOLF

Violation Issued: No

Type: Full
Date: 04/01/25
Time: 14:30:00
Report: 8087251083
Rose Arbor/Wildflower Lodge

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding: MILK
Temperature: 26 Degrees Fahrenheit - Location: REFRIGERATOR - WOLF
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 26 Degrees Fahrenheit - Location: REFRIGERATOR - WOLF
Violation Issued: No

Process/Item: Ambient Air
Temperature: -6 Degrees Fahrenheit - Location: BAKERY FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: -7 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: PORK
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: GROUND BEEF
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHICKEN
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 37 Degrees Fahrenheit - Location: SERVER COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: SERVER COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 35 Degrees Fahrenheit - Location: SERVER COOLER
Violation Issued: No

Type: Full
Date: 04/01/25
Time: 14:30:00
Report: 8087251083
Rose Arbor/Wildflower Lodge

Food and Beverage Establishment Inspection Report

Page 3

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	0

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH NURSE EVALUATOR TESA BROWN AND FOOD SERVICE DIRECTOR DARREN PHIPPS.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087251083 of 04/01/25.

Certified Food Protection Manager: _____

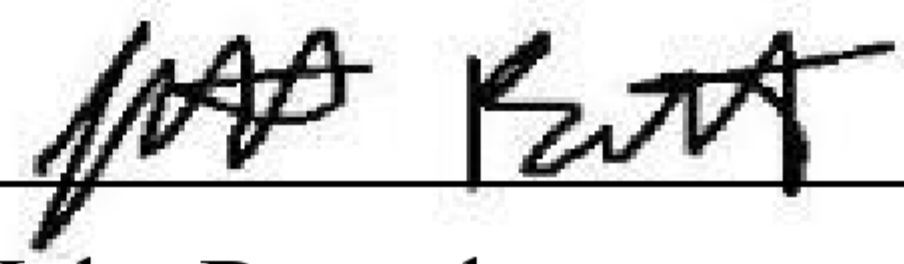
Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

DARREN PHIPPS
FOOD SERVICE DIRECTOR

Signed: _____


John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
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