Electronically Delivered

December 23, 2025

Licensee
Landings of Minnetonka
14505 Minnetonka Drive
Minnetonka, MN 55345

RE: Project Number(s) SL20107017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF MINNETONKA	14505 MINNETONKA DRIVE MINNETONKA, MN 55345

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20107017-0 On December 1, 2025, through December 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 61 residents all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 1, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and 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 establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to appropriate lancet devices used during blood glucose monitoring and cleaning of blood glucose monitoring supplies. 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).	0 510		

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0 510	Continued From page 4 The findings include: On December 2, 2025, at 8:29 a.m., the surveyor observed unlicensed personnel (ULP)-G apply a new pair of gloves, pick up a lancet device labeled 120 [R5's room number] from the medication cart, and search for lancet needles for the device. ULP-G then put the lancet device back into the medication cart, picked up a different lancet device labeled 117, and placed a needle into the Microlet Next lancet device. ULP-G walked over to R5, pricked R5's right second finger with the lancet device, took R5's blood glucose reading, and returned to the medication cart. ULP-G cleaned the lancet device with alcohol wipes, then placed the lancet device back into the medication cart. ULP-G stated they used the lancet device labeled 117 because they were unable to find a needle to fit into the lancet device labeled 120. ULP-G stated they cleaned blood glucose devices with alcohol. On December 2, 2025, at 10:36 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated residents had their own blood glucose monitoring equipment however, the licensee did have facility blood glucose monitoring equipment in case a resident's malfunctioned or if a resident was not able to get diabetic supplies due to insurance complications. LALD/RN-D stated they cleaned the shared equipment with the wipes located on the medication carts. The surveyor asked to see the licensee's shared blood glucose equipment. On December 2, 2025, at 10:43 a.m., clinical nurse supervisor (CNS)-C asked ULP-A to see the stock blood glucose monitoring kit. The surveyor observed the kit contained test strips, an	0 510		

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0 510	Continued From page 5 Accu-Check monitor, and an Accu-Chek Softclix lancet device. The surveyor explained how the Accu-Chek Softclix device was meant for single resident use. ULP-A then stated only one resident was using the kit. The surveyor inquired why the kit was not labeled with the resident's information. ULP-A stated it was located by the resident's medications in the medication cart. The surveyor asked to see the blood glucose monitoring supplies that were shared with other residents. The surveyor was taken to the licensee's medication room. ULP-F and ULP-G showed the surveyor lancet needles that were meant to be placed in single use pens. CNS-C acknowledged the licensee did not have appropriate lancet devices to be used with shared blood glucose equipment and stated they would purchase appropriate lancets. On December 3, 2025, at 1:18 p.m., the surveyor observed the licensee had appropriate disinfectant wipes available to clean shared blood glucose equipment, however, the appropriate wipes were not utilized by ULP-G during the December 2, 2025, observation. The Centers for Disease Control's (CDC), considerations for Blood Glucose Monitoring and Insulin Administration dated August 7, 2024, indicated to never use fingerstick devices for more than one person. The undated manufacturer's instructions for Microlet Next indicated the device was intended for single patient use only. In addition, the device should be cleaned and disinfected with a super sani-cloth germicidal wipe. The undated manufacturer's instructions for Accu-Chek Softclix indicated Accu-Chek Softclix	0 510		

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0 510	Continued From page 6 lancing device was intended for personal use only and was only allowed to be used to obtain blood from one person. The licensee's 7.32 Blood Sugar Testing- Shared Equipment Use policy dated February 1, 2023, indicated staff would follow the manufacturer's instructions for proper use of the specific glucometer being used. The policy did not address following the manufacturer's instructions for the lancets being used during blood glucose monitoring. In addition, the glucometer would be disinfected by following the manufacturer's instructions, making sure any product used was effective against blood borne pathogens. The policy did not address disinfecting of lancet devices. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 775		

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0 775	Continued From page 7 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Decemeber 1, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

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0 780	Continued From page 8 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Decemeber 1, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 780		

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0 780	Continued From page 9 days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Decemeber 1, 2025, for the specific violations	0 800		

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0 800	Continued From page 10 related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part	01620		

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01620	Continued From page 11 of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for 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 on July 31, 2023, and	01620		

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01620	Continued From page 12 began receiving assisted living services. R5's diagnoses included borderline personality disorder, anxiety disorder, depression, HTN, diabetes mellitus, COPD, and chronic systolic congestive heart failure. R5's Addendum A -A Service Plan signed July 1, 2025, indicated R5 received assistance for toileting, positioning, and transfers. R5's record included 90-day assessments dated April 18, 2025, July 19, 2025, and October 1, 2025, which indicated 92 days passed between the April and July assessment. On December 3, 2025, at 10:09 a.m., CNS-C stated R5's assessment was late because they were having issues with Eldermark opening new assessments. The licensee's Assessments, Reviews & Monitoring dated February 1, 2023, indicated ongoing resident assessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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.	01640		

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01640	Continued From page 13 (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 implement and/or have an accurate service plan for four of four residents (R2, R3, R4, 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 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 multiple documents that	01640		

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01640	Continued From page 14 included "service plan" in the title. Addendum -A Service Plan was a paper formatted document. The document was the agreement between the licensee and the resident which included services to be provided and signatures from the resident or resident representative and the licensee's representative to authenticate agreement on the services to be delivered. The document titled Service Plan was an electronically formatted document in Eldermark (a documenting software) that directed (fed information to) the service documentation record for unlicensed personnel (ULP) to document on services provided. R2 R2 admitted to the licensee on July 1, 2024, and began receiving assisted living services. R2's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and depression. R2's paper formatted, Addendum A -Service Plan signed July 1, 2025, included medication administration daily as ordered by physician and as needed, treatments as ordered by physician, bathing twice weekly and as needed, grooming daily and as needed, dressing, toileting daily and as needed, laundry two times weekly and as needed, housekeeping daily and as needed, walking, socialization daily and as needed, positioning and transfers daily and as needed, and metal health monitoring daily and as needed. R2's Support Plan dated November 1, 2024, through October 31, 2025, indicated the licensee was paid for medication administration, housekeeping, meals three times a daily with one to two snacks, dressing, grooming, bathing, toileting, walking daily and as needed, wheelchair	01640		

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01640	Continued From page 15 mobility, transfers, and behavior management. R2's Uniform Assessment Tool Dated November 24, 2025, indicated R2 was independent with transfers and bed mobility. R2's documentation of services delivered from November 30 to December 1, 2025, indicated R2 received assistance with oxygen, dining, lymphedema wraps, grooming, dressing, socialization, housekeeping, bathing, and managing behaviors. R2's Eldermark Service Plan printed on December 2, 2025, included managing behaviors, oxygen, dining, socialization, bathing, dressing, grooming, and lymphedema wraps to be completed on R2. On December 3, 2025, at 10:09 a.m., the surveyor questioned why the Addendum A -Service Plan did not align with R2's services delivered and R2's nursing assessment. The licensee provided another Eldermark Service Plan. R2's Eldermark Service Plan printed on December 3, 2025, included managing behaviors, grooming, dining, bathing, dressing, socialization, laundry, housekeeping, transfers as needed daily at 9:00 a.m., toileting as needed at 8:00 a.m., 4:00 p.m. R2's record lacked any documentation for the service of walking. In addition, there was no ULP documentation for toileting or transfers being provided to R2 which was a service scheduled daily and as needed per R2's signed service plan. R3	01640		

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01640	Continued From page 16 R3 admitted to the licensee on January 18, 2024, and began receiving assisted living services. R3's diagnoses included hypertension (HTN), diabetes mellitus type 2 (DM2), anxiety disorder, depression, and atrial fibrillation. R3's paper formatted, Addendum A- Service Plan signed July 1, 2025, indicated R3 received assistance for medications daily as ordered by physician and as needed, treatments as ordered by physician, bathing twice weekly and as needed, grooming daily and as needed, dressing daily and as needed, toileting daily and as needed, laundry two times weekly and as needed, housekeeping daily and as needed, meals three times per day with one to two snacks, socialization daily and as needed, mental health management daily and as needed, and positioning and transfers daily and as needed. R3's Support Plan dated January 1, 2025, through December 31, 2025, indicated the licensee was paid for housekeeping, meals, dressing, grooming, bathing, wheelchair mobility, transferring, medication management, mental health management, and other delegated tasks. R3's Uniform Assessment Tool dated October 13, 2025, indicated R3 was independent with incontinent care, transfers, and bed mobility. R3's documentation of services delivered from November 27, 2025, through December 2, 2025, indicated R3 received assistance with behavior management, meals, bathing, socialization, dressing, grooming, and housekeeping. R3's Eldermark Service Plan printed December 2, 2025, included bathing, vital signs, laundry,	01640		

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01640	Continued From page 17 housekeeping, socialization, dressing, grooming, behavior management, and meals. On December 3, 2025, from 10:09 a.m., the surveyor questioned why the Addendum A -Service Plan did not align with R3's services delivered and R3's nursing assessment. The licensee provided another Eldermark Service Plan. R3's Service Plan printed December 3, 2025, included transfers as needed, bathing, grooming, socialization, vital signs, laundry, housekeeping, socialization, dining, dressing, grooming, and behavior management. R3's record lacked any documentation for the service of toileting. In addition, there was no ULP documentation for transfers or positioning being provided to R3 which was scheduled daily and as needed. R4 R4 admitted to the licensee on November 20, 2025, and began receiving assisted living services. R4's diagnoses included post-traumatic stress disorder (PTSD), depression, and anxiety. R4's paper formatted, Addendum A- Service Plan signed November 20, 2025, included medication administration daily as ordered by physician and as needed, treatments as ordered by physician and as needed, laundry two times weekly and as needed, housekeeping daily and as needed, meals three times daily and one to two snacks daily, socialization daily and as needed, and mental health management daily and as needed.	01640		

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01640	Continued From page 18 R4's medical record lacked prescribed treatments. R4's documentation of services delivered from November 27, 2025, through December 2, 2025, indicated R4 received assistance with behavior management, laundry, dining, housekeeping, socialization, bathing, dressing, and grooming. R4's Eldermark Service Plan dated December 2, 2025, included dining, housekeeping, behavior management, dressing, laundry, bathing, laundry, grooming, and socialization. R4's signed service plan did not include the services of dressing, grooming, or bathing which R4 had received services for. R4's signed service plan included treatments, which R4 did not have any prescribed treatments. R5 R5 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R5's diagnoses included borderline personality disorder, anxiety disorder, depression, HTN, diabetes mellitus, and COPD, chronic systolic congestive heart failure. R5's paper formatted, Addendum A- Service Plan signed July 1, 2025, indicated R5 received medication administration daily as ordered by physician and as needed treatments as ordered by physician, bathing twice weekly and as needed, grooming daily and as needed, dressing, daily and as needed, toileting daily and as needed, laundry twice weekly and as needed, housekeeping daily and as needed, meals three times daily with one to two snacks, socialization daily and as needed, positioning and transfers	01640		

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01640	Continued From page 19 daily and as needed, and mental health management daily and as needed. R5's documentation of services delivered from November 27, 2025, through December 2, 2025, indicated R5 received laundry, meals, oxygen assistance, behavior management, lymphedema wraps, housekeeping, socialization, dressing, grooming, and bathing. R5's Eldermark Service Plan printed December 2, 2025, included oxygen, bathing, dressing, meals, vital signs, behavior management, laundry, housekeeping, lymphedema wraps, grooming, and socialization. On December 3, 2025, from 10:09 a.m., the surveyor questioned why the Addendum A -Service Plan did not align with R5's services delivered and R5's nursing assessment. The licensee provided another Eldermark Service Plan. R5's Eldermark Service Plan printed December 3, 2025, included oxygen, toileting as needed at 8:00 a.m. and 8:00 p.m., transfers as needed at 8:00 p.m., bathing, dressing, meals, vital signs, behavior management, laundry, housekeeping, lymphedema wraps, and socialization. R5's record did not include ULP documentation for the services of toileting, positioning, or transfers which were supposed to occur daily and as needed. On December 3, 2025, at 10:09 a.m., RN-H stated R5 was independent with transfers, bed mobility, and toileting. The surveyor inquired why R5's service plan included toileting, transfers, and bed mobility if they were independent and did not	01640		

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01640	Continued From page 20 require the services. RN-H stated R5 might need assistance with wiping when sitting on a toilet and they believed R5 required assistance with positioning when they were sick. The surveyor then inquired why services were not removed if or when they were no longer needed. Clinical nurse supervisor (CNS)-C and RN-H stated nurses did not create or revise the service plan. RN-H stated nurses only provided input for the service plan. CNS-C stated they would get the person who created all the service plans to talk to the surveyor. RN-H stated nurses would add services to the computer system that the resident needed. The surveyor inquired if they were receiving the services, why there was no documentation on the services being provided. RN-H said they missed the documentation. CNS-C stated Eldermark (a documenting software) was deleting information off of the assessments when they finalized the assessments. Licensed assisted living director (LALD/RN)-D stated the resident's service plans were created off of the 6970 [support plan]. The surveyor again inquired if the residents were receiving the services identified, why there was no documentation of the services being provided. RN-H again said they missed the documentation. LALD/RN-D stated a majority of their residents had mental health issues, and the 6790 [support plan] and the state Minnesota (MN) Choice assessment would show what services the resident needed, and the licensee relied on the MN Choice assessment to create their service plan rather than having their nurses' assessment guide the services. LALD/RN-D stated the licensee knows what to do for the resident because MN Choice assessment tells them the services they need to provide for the resident. LALD/RN-D stated during the residents nursing assessments the nurses ask what the residents needs help with however, many residents will	01640		

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01640	Continued From page 21 state they do not have an issue completing a task but do. CNS-C stated they did not always have access to the MN Choice assessment with them when they completed their nursing assessment on a resident, and they documented on the assessment what they observed at the time with the resident. The surveyor explained how their service plans should be based off the assessment the facility nurses were seeing and should accurately reflect the services required/delivered. CNS-C stated again the Eldermark system was responsible for the discrepancies and finalizing assessments. CNS-C stated the licensee had submitted multiple tickets to Eldermark to fix the issues however, they had not been fixed, and the licensee was thinking of changing systems. The staff member who created the service plan did not come and speak with the surveyor. On December 3, 2025, at 11:05 a.m., the surveyor inquired why R4's service plan indicated they had treatments. RN-H stated they had no treatments, and they would have to ask another RN why it was marked that way. On December 3, 2025, at 11:05 a.m., RN-H stated R4 was marked for treatments due to vital signs being taken. The surveyor asked for a prescriber's order on vital signs. The surveyor did not receive a prescriber's order prior to the exit of the survey. On December 3, 2025, at 11:37 a.m., RN-H stated if there was any conflicting information between the service plan not matching the nursing assessment for what services the residents needed it would be due to issues with the Eldermark system.	01640		

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01640	Continued From page 22 On December 3, 2025, at 12:00 p.m., R5 stated they were independent with toileting, transfers, ambulation, bed mobility, and wheelchair mobility. Despite review of resident assessments, Support Plans, Addendum - A Service Plans, and Eldermark Service plans, the surveyor was unable to discern what services R2, R3, R4, and R5 were supposed to be receiving. The licensee's 6.08 Service Plan policy dated February 1, 2023, indicated service plans were based on the outcomes of assessments, reassessment, monitoring and individual reviews of the resident's needs and preferences. The licensee would implement and provide all services indicated in the service plan. The licensee's 6.10 Service Plan Modification policy dated February 1, 2023, indicated when a resident received assisted living services and a change(s) to the service plan occurred, the service plan must be amended in writing and signed by the resident or resident's designated representative. If the service plan needed to be modified due to a change the Service Plan Modification form would be completed; this form included described changes in service and whether the service was added, changed, or discontinued. 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	01730		

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01730	Continued From page 23 (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	01730		

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01730	Continued From page 24 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 observation, interview, and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for four of four residents (R2, R3, R4, 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 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 admitted to the licensee on July 1, 2024, and began receiving assisted living services. R2's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and depression. R2's Addendum A - Service Plan signed July 1, 2025, included medication administration. R2's Uniform Assessment Tool dated November 24, 2025, indicated R2 received medication assistance, nurses were responsible for supplies and ordering refills, ULP were delegated oral,	01730		

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01730	Continued From page 25 otic, buccal, sublingual, topical, rectal, nasal, ocular, subcutaneous, and inhaled medications, and medications were stored in the locked medication cart and room. R2's medication administration record (MAR) dated November 1, 2025, through December 1, 2025, included the following orders: - Narcan 4mg instill one spray in one nostril as a single dose. May repeat every 2-3 minutes in alternating nostrils; and - minerin cream apply to affected areas four time daily as needed. The MAR lacked an indication for Narcan to be given and lacked an area minerin cream would be applied. R3 R3 admitted to the licensee on January 18, 2024, and began receiving assisted living services. R3's diagnoses included hypertension (HTN), diabetes mellitus type 2 (DM2), anxiety disorder, depression, and atrial fibrillation. R3's Addendum A - Service Plan signed July 1, 2025, included medication administration. R3's Uniform Assessment Tool dated October 13, 2025, indicated R3 received medication administration, medications were stored in a locked medication cart and medication room, nurse was responsible for monitoring supplies and refills, ULP were delegated oral, buccal, sublingual, topical, rectal, nasal, ocular, subcutaneous, inhaled, and vaginal medication administration. R3's MAR dated November 1, 2025, through December 1, 2025, included the following orders:	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF MINNETONKA	14505 MINNETONKA DRIVE MINNETONKA, MN 55345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 26 - calcipotriene cream 0.005 percent (%) apply to affected area on body twice daily; - pimecrolimus cream 1% apply topically twice daily for two weeks during triamcinolone breaks, use with calcipotriene; and - calmoseptine ointment apply a thin layer topically to affected area three times daily as needed. The MAR lacked the following: - an indication for use for calcipotriene cream and the area the cream would be applied; - an indication for pimerolimus cream and the area the cream would be applied; and - an indication for calmospetine ointment and the area the cream would be applied. R4 R4 admitted to the licensee on November 20, 2025, and began receiving assisted living services. R4's diagnoses included post-traumatic stress disorder (PTSD), depression, and anxiety. R4's Addendum A - Service Plan signed November 20, 2025, included medication administration. R4's Uniform Assessment Tool dated December 1, 2025, indicated R4 received medication administration, medications were locked in medication cart, medication room or locked medication cabinet in R4's room, the nurse was responsible for monitoring supplies and ordering refills on a timely basis, medications that could be delegated to ULP were oral, otic, buccal, sublingual, topical, rectal, nasal, ocular subcutaneous, inhaled, and vaginal medications.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF MINNETONKA	14505 MINNETONKA DRIVE MINNETONKA, MN 55345

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01730	Continued From page 27 R4's MAR dated November 1, 2025, through December 1, 2025, included the following orders: - Senexon-S 8.6 mg-50 mg take one to two tablets by mouth twice daily; - trazodone 50 mg take one to two tablets by mouth at bed time; - clonazepam 0.5 mg take one tablet my mouth once daily as needed; - hydroxyzine pamoate 50 mg take one capsule by mouth every six hours as needed; - olanzapine 5 mg take one to two tablets by mouth three times per day for anxiety; and - quetiapine 50 mg take one tablet by mouth four times daily as needed. R4's MAR lacked the following: - specific instructions on when to take one tablet vs two tablets of Sennoxon-S; - specific instructions o when to take one tablet vs two tablets of trazodone; - an indication for use for clonazepam; - an indication for use for hydroxyzine pamoate; and - an indication of use for quetiapine. On December 2, 2025, at 6:55 a.m., the surveyor observed ULP-F administer oral medications to R4. In addition, the surveyor observed ULP-F provide R4 with two tablets of Senexon-S 8.5 mg-50 mg without asking the resident how many tablets they would like. R5 R5 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R5's diagnoses included borderline personality disorder, anxiety disorder, depression, HTN, diabetes mellitus, COPD, and chronic systolic congestive heart failure.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF MINNETONKA	14505 MINNETONKA DRIVE MINNETONKA, MN 55345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 28 R5's Addendum A - Service Plan signed July 1, 2025, included medication administration. R5's Uniform Assessment Tool dated October 1, 2025, indicated R5 medications were administered by staff, medications were locked in medication cart and medication room, nurse was responsible for monitoring supplies and ordering refills on a timely basis, medications that may be delegated to ULP included oral, otic, buccal, sublingual, topical, rectal, nasal, ocular, subcutaneous, inhaled, and vaginal. R5's MAR dated November 1, 2025, through December 1, 2025, included the following medication orders: - nystatin powder 100,000 g apply to affected area(s) twice daily; - albuterol sulfate inhaler 90 mcg inhale two puffs by mouth every four hours as needed; - calcium antiacid 500 mg chew and swallow one to two tablets by mouth as needed for acid reflux; - Diclofenac gel 1 % apply 1 g topically to affected joints twice daily as needed. Max 16 grams per 24 hours. Ok to keep at bedside; - ketoconazole cream 2% apply topically to affected areas twice daily as needed; and - triamcinolone acetate 0.1 % cream apply to affected areas topically three times daily as needed. R5's MAR lacked the following: - the location nystatin would be applied to; - an indication for albuterol sulfate; - specific instructions on when to take one tablet vs two tablets of calcium antiacid 500 mg; - the location diclofenac gel would be applied to; - the location ketoconazole cream would be applied to;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 29 - the location triamcinolone acetate cream would be applied to. R2, R3, R4 and R5's medication management plan comprised of multiple documents lacked documentation for specific resident instructions relating to the administration of medications. On December 3, 2025, at 10:42 a.m., registered nurse (RN)-H stated the pharmacy entered in the prescriber's orders into Eldermark (a documenting software program), and then nursing verifies the order pharmacy put into the system. RN-H stated nursing accepts the order or rejects the order the pharmacy entered prior to the order being uploaded to the MAR for ULP to administer. RN-H stated they have to call the pharmacy if they do not like how each medication order is entered into the system. RN-H stated the Eldermark system did not allow nursing to add additional instructions or indications to medications in the MAR. The licensee's 7.03 Medication Management Individualized Plan dated February 1, 2023, indicated the individualized medication management record for each resident would include documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 30 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for three of 25 residents (R6, R7, R8). In addition, the licensee failed to label medication with a prescription label for one of 25 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: On December 1, 2025, at 1:23 p.m., the surveyor observed the second-floor medication cart, which stored the medications for 25 residents, and observed the following expired medication and unlabeled medications: - R6 acetaminophen 500 milligrams (mg) with and expiration date of March 26, 2025; - R7 acetaminophen 325 mg with an expiration date of June 10, 2025, and polyethylene glycol 3350 grams (g) with an expiration date of March 17, 2025; - R8 hydroxyzine hydrochloride (HCL) 50 mg with	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 31 and expiration date of November 11, 2025, and trazodone 100 mg with an expiration date of October 1, 2025; - an unlabeled bottle of Nature's Bounty Sleep 3 10 mg melatonin; and - unlabeled NovoLog FlexPens dated November 29, 2025, and December 27, 2025. Unlicensed personnel (ULP)-J stated they did not know who the melatonin belonged to and "maybe someone put it in the cart." ULP-J stated the NovoLog FlexPens belonged to R5. On November 1, 2023, at 1:43 p.m., registered nurse (RN)-H stated nurses audited the medication carts monthly for expired or discontinued medications, and ULP were trained to bring expired medication to the nurses. RN-H stated the nurses reviewed a lot of medications during their cart audit, and the medications listed above were missed. RN-H stated they licensee supplied a sticker to place on medication to label any medications that lacked a label. The licensee's 7.23 Medication Disposal policy dated February 1, 2023, indicated expired prescription drugs managed by the licensee would be disposed of according to the accepted practices of Minnesota board of Pharmacy and the labels from the containers would be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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	20107	A. BUILDING: _____ B. WING _____	12/03/2025

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02310	Continued From page 32 (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 standards, medical or nursing standards for four of four residents (R2, R5, R9, R11) who utilized oxygen. 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 December 1, 2025, at 1:13 p.m., the environmental engineer surveyor observed one home fill machine and seven portable cylinder tanks with one of the tanks on their side on the floor R11's room. Six of the seven portable cylinders were not stored properly in noncombustible racks in R11's room. On December 1, 2025, at 1:21 p.m., the environmental engineer surveyor observed seven portable oxygen cylinder tanks in R5's room. All seven of the portable cylinders were not stored properly in noncombustible racks in R5's room.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

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02310	Continued From page 33 On December 1, 2025, at 1:54 p.m., the environmental engineer surveyor observed one home fill machine and four portable cylinder tanks in R9 room. Three of the four portable cylinders were not stored properly in noncombustible racks in R9's room. On December 2, 2025, at 11:40 a.m., the surveyor observed one home fill machine and seven portable oxygen cylinder tanks in R2's room. Five of the portable cylinders were not stored properly in noncombustible racks in R2's room. Unlicensed personnel (ULP)-A stated they did not know why the oxygen was not secured in racks. On December 2, 2025, at 11:47 a.m., registered nurse (RN)-H stated oxygen should be stored in a resident's room in an oxygen cart or an oxygen cylinder rack. RN-H stated staff were trained to keep oxygen cylinders in an upright position. The surveyor inquired why the resident's listed above oxygen cylinders were not stored properly in resident rooms. RN-H stated, "they should have it." The licensee's 7.40 Oxygen policy dated February 1, 2023, indicated oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	12/03/2025

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02310	Continued From page 34 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

Landings of Minnetonka
14505 Minnetonka Drive
Minnetonka, MN 55345
Hennepin County
Parcel:

Phone:

License Info

License: HFID 20107

Risk:
License:
Expires on:
CFPM: Yaxye Bashi
CFPM #: 58847; Exp: 5/28/2028

Inspection Info

Report Number: F7994251166
Inspection Type: Full - Single
Date: 12/1/2025 Time: 12:35:29 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

New Order: 3-500A Microbial Control: cooling
3-501.15A *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.
COMMENT: FOODS ARE PLACED IN DEEPER CONTAINERS TO COOL. UTILIZE THE ABOVE GUIDELINES FOR COOLING.
Comply By: 12/1/2025 Originally Issued On: 12/1/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C1 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.
COMMENT: DISHWASHER FOUND NOT REACHING REQUIRED CHLORINE CONCENTRATION.
Comply By: 12/1/2025 Originally Issued On: 12/1/2025

New Order: 5-200A Plumbing: approved materials/design
5-201.11B *Priority Level: Priority 3 CFP#: 51*
MN Rule 4626.1040B Maintain the plumbing system in good repair.
COMMENT: SINK FAUCET AND BACK FLOW PREVENTION DEVICE ON DISHWASHER ARE LEAKING. REPAIR/REPLACE THESE ITEMS.
Comply By: 12/1/2025 Originally Issued On: 12/1/2025

Food & Beverage General Comment

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

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

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

I acknowledge receipt of the Metro District Office inspection report number F7994251166 from 12/1/2025

Establishment Representative

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

Minnesota (MDH) Version
EH Manager; RPT: F7994251166

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	1	Date: 12/1/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:35:29 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Landings of Minnetonka	14505 Minnetonka Drive	Minnetonka, MN	55345	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 20107		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	N/A	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33	X	Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Crystal Elva

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20107017	**Date:** 12/1/2025
Facility Name: Landings of Minnetonka	
Facility Address: 14505 Minnetonka Drive	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2

2. A working space of not less than 36 inches (914 mm) in width, 36 inches (914 mm) in depth and 78 inches (1981 mm) in height shall be provided and maintained in front of and to the sides of wall-mounted fire department connections and around the circumference of free-standing fire department connections, except as otherwise required or *approved* by the *fire code official*. [Minn. Stat. 144G.45 subd. 2; MSFC 912.4.2]

   Comments: The access to the fire department connection was obstructed by the placement of two chairs placed in front of the connection.

3. In buildings protected by automatic sprinklers or automatic fire detectors, suspended or removable ceiling tiles shall be maintained in place to prevent the delay in sprinkler or detector activation. [Minn. Stat. 144G.45 subd. 2; MSFC 901.11]

   Comments:

   Drop tiles were absent around the sprinkler head in the hallway near room 111 thus leaving a space around the sprinkler head and potentially delaying the initiation of the head in event of a fire.

   There were holes in the drop tile ceiling in the first-floor employee breakroom that could affect operation of sprinkler heads in event of a fire.

   There were holes in the drop tile ceiling in the first-floor laundry room that could affect operation of sprinkler heads in event of a fire.

4. Interior vertical shafts, including stairways, elevator hoistways, and service and utility shafts, that connect two or more stories of a building, shall be enclosed or protected as specified. Vertical openings connecting two or more stories in Group I occupancies require 1-hour protection. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.4]

   Comments: The ceiling in the first-floor kitchen mop closet had been removed and a vertical opening was created leading up into the floors above to accomplish repair work according to building administrator (A)-E. The vertical opening extended at least one floor above without required protection.

5. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

   Comments: The dryer vent was loose and there was an accumulation of lint behind the clothes dryer in the first-floor laundry room.

6. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: The self-closer on the salon door was not functional when tested and failed to pull the door closed.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments:

   The smoke alarms provided in resident room 121 were not interconnected.

   The smoke alarms provided in resident room 202 were not interconnected.

   The smoke alarms provided in resident room 218 were not interconnected.

   The smoke alarms provided in resident room 302 were not interconnected

2.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments:
   Bathroom vanity lights were not functional when tested in resident room 110

   The vent cover in the laundry room was visibly dirty and covered in lint.

   There were stains on the walls in the living room of resident room 121.

   There was a sharp metal shim that was wedged into the door frame of resident room 227 in the frame of the unit door. The metal piece could catch on clothing or cut someone passing through the door.

   There was water damage to the cabinet under the sink in resident room 225.

   The trim around the closet was damaged and hanging loose in resident room 211.

   The vent cover was missing from the bathroom vent in resident room 211.

   There was damage to the walls including several small holes in resident room 211.

   The toilet seat was disconnected from the toilet in resident room 211.

   The vent cover was missing from the bathroom vent in resident room 218

   The trim around the closet was damaged and hanging loose in resident room 309.