Electronically Delivered

August 26, 2025

Licensee
New Horizon Assisted Living LLC
7119 Girard Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL39171016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39171	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON ASSISTED LIVING LLC	7119 GIRARD AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39171016-0 On June 30, 2025, through July 2, 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 four residents; all 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 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		
0 650 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 infomation: (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 review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-B) who performed treatment administration. This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 4 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 was hired on August 24, 2023, to provide direct care services to residents. On July 1, 2025, at 8:53 a.m., surveyor observed ULP-B check R1's blood glucose by pushing a button on the Freestyle Libre 3 reader (device that obtains blood glucose levels using a sensor attached to the back of upper arm) prior to setting up insulin (reduces blood glucose levels). ULP-B's record included a blood glucose testing competency completed on September 1, 2023, using the finger prick using a needle to obtain a blood sample. ULP-B's personnel file lacked documentation of training and competency on R1's Freestyle Libre 3 continuous glucose monitoring system. During interview on July 1, 2025, at 10: 15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A said she trained all staff on R1's continuous glucose monitoring system but did not document the training and competency for anyone. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated the registered nurse would complete training and competency for nursing delegated	0 650		

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0 650	Continued From page 5 tasks and would maintain a copy of all education, training, and competency testing in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 6 by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in the Appendix Z. 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 potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan dated June 23, 2023, lacked evidence of the following required content: -developed strategies for addressing facility and community-based risks (EP included shelter in place and evacuation); -missing resident plan; -developed policies and procedures based on the risk assessment; and -documentation the plan was reviewed/revised annually. During interview on June 30, 2025, at 2:35 p.m., owner/director of operations (O/DO)-D stated he reviewed the EP with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and their program manager annually but did not have documentation to provide to the surveyor. O/DO-D provided policies and procedures based on their risk assessment and the missing resident plan from their policy and procedure binder and	0 680		

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0 680	Continued From page 7 was unaware they needed to be included in the EP plan. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance dated August 1, 2021, indicated the licensee's EP plan would align with the Centers for Medicare and Medicaid Services State Operational Manual Appendix Z and include all required elements. The plan would be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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, 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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 8 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 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 July 1, 2025, from approximately 1:35 p.m. to 3:10 p.m., the surveyor toured the facility with owner/director of operations (O/DO)-D. During the tour, the surveyor observed the following deficient conditions: The dryer vent was not properly attached to the dryer in the laundry room. The dryer vent should be reattached and maintained in a properly functional manner to prevent buildup of lint that could pose a fire hazard. The facility contained an old fire alarm system including smoke detectors, horn strobes and a fire alarm panel that are no longer functional. Records on the fire alarm panel indicate that it had last received servicing on 8/25/2001. O/DO-D stated that the alarm system is a remnant of previous owners and that no part of the system is functional. The presence of such items gives the appearance of safety devices and should be removed or restored to proper working order and maintained. During the facility tour interview on July 1, 2025, O/DO-D verified the above listed physical environment observations while accompanying on the tour.	0 800		

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0 800	Continued From page 9 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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0 810	Continued From page 10 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 required content. 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 July 1, 2025, at approximately 2:30 p.m., owner/director of operations (O/DO)-D and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), and evacuation drills for the facility. The licensee FSEP failed to include the following: Record review indicated the licensee failed to provide training to residents at least once per year. O/DO-D and LALD/CNS-A provided documentation of training for residents on the fire safety and evacuation plan at their time of move in. No further documentation of trainings was provided regarding resident trainings provided. LALD/CNS-A and O/DO-D stated that they were not conducting annual trainings for residents currently, but indicated they would develop such trainings. Residents who are capable of assisting in their evacuation should be provided training at	0 810		

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0 810	Continued From page 11 least once a year. During an interview on July 1, 2025, at approximately 12:50 p.m., the surveyor explained the requirements for employee trainings, resident trainings, FSEP documentation, and evacuation drills. LALD/CNS-A and O/DO-D stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for one of one resident (R1). 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	0 970		

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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
0 970	Continued From page 12 the residents). The findings include: R1 had diagnoses including bipolar disorder, mania with grandiosity, borderline personality disorder, and major depressive disorder. R1's Service Plan (Waiver)-Addendum to Contract dated July 1, 2025, indicated R1 received services including assistance with housekeeping, laundry, transfers, bathing, safety checks, dressing, toileting, behavior management, and treatment and medication administration. R1's [Licensee] Resident Contract for Assisted Living dated July 13, 2023, and the licensee's blank contract provided included the following language indicating a waiver of liability: "PROVISIONS RELATED TO OUR RESPECTIVE RESPONSIBILITIES B. Insurance. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to the Community upon request. The resident acknowledges that the Community is not an insurer of the resident's person or property." During phone interview on July 2, 2025, at 11:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the waiver of liability language requirement. LALD/CNS-A said she believed she provided the most updated version since her last survey.	0 970		

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	39171	A. BUILDING: _____ B. WING _____	07/02/2025

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0 970	Continued From page 13 The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, indicated when a prospective resident decides to move into [licensee] a signed assisted living contract was signed and received by the facility. The contract must be reviewed with the prospective resident and/or responsible person and answer any questions they may have. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (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;	01730		

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01730	Continued From page 14 (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health 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 develop and maintain a current individualized medication management record to include all required content for one of one resident (R1) who received assistance with medication administration and management. 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	01730		

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01730	Continued From page 15 a large portion or all of the residents). The findings include: R1 had diagnoses including diabetes type 2, bipolar disorder (mood swings from mania to depression), mania with grandiosity, borderline personality disorder (mental health condition that affects the way people feel about themselves and others), and major depressive disorder. R1's Service Plan (Waiver)-Addendum to Contract dated July 1, 2025, indicated R1 received services including assistance with housekeeping, laundry, transfers, bathing, safety checks, dressing, toileting, behavior management, blood glucose checks, and medication administration. During observation on July 1, 2025, between 8:53 a.m. and 9:50 a.m., unlicensed personnel (ULP)-B checked R1's blood glucose (BG) meter which read 180 mg/dL (milligrams per deciliter). ULP-B stated R1 had chocolate milk earlier in the morning but did not say when and did not have breakfast. ULP-B set up R1's oral medications. ULP-B grabbed R1's Lantus flex pen (slow acting insulin) and aspart flex pen (fast acting insulin). ULP-B dialed the Lantus flex pan to 20 units and aspart was dialed to 14 units per R1's medication administration record's (MAR) insulin sliding scale based on BG results. ULP-B grabbed a "Snack Pack" pudding, needles, and alcohol wipes and went to R1's room where they administered the oral medications with pudding. ULP-B placed needles on each flex pen without priming (process of removing any air bubbles by dialing two units and wasting it to ensure the most accurate dose) and administered the insulins. R1 wanted to go back to bed and ULP-B helped R1	01730		

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01730	Continued From page 16 lay down and applied covers and left the room. At 10:53 a.m., ULP-B informed the surveyor that R1 was ready to get out of bed. It took R1 and ULP-B approximately 20 minutes to get dressed and transferred to wheelchair and brought to the dining room table for a meal. DOCUMENTATION OF INSULIN GIVEN R1's Med Admin Summary (medication administration record-MAR) dated June 1, 2025, through July 1, 2025, indicated R1 took the following insulin: -insulin aspart flexpen-inject 12 units with breakfast plus 2/50> 150 sliding scale up to 80 units daily. Use insulin sliding scale (SS) below: BG 149 or less-12 units; If BG 150-199, give 14 units; If BG 200-249, give 16 units; If BG 250-299, give 18 units; If BG 300-349, give 20 units; If BG 350-399, give 22 units; and If BG over 400, give 24 units. -insulin aspart flexpen-inject 10 units with lunch (12:00 p.m.) and dinner (6:00 p.m.) plus 2/50> 150 sliding scale up to 60 units daily. Use insulin sliding scale (SS) below: Blood glucose (BG) 149 or less-10 units; If BG 150-199, give 12 units; If BG 200-249, give 14 units; If BG 250-299, give 16 units; If BG 300-349, give 18 units; If BG 350-399, give 20 units; and If BG over 400, give 22 units. R1's MAR was initialed by various staff 93 times/entries and out of the 93 initials/entries, 59 initials/entries did not document amount of aspart insulin given per sliding scale. R1's provider orders dated April 14, 2025, read the same instructions for insulin aspart flexpan as	01730		

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01730	Continued From page 17 indicated on R1's MAR. RESIDENT SPECIFIC INSTRUCTION FOR HOLDING INSULIN R1's medical record included instructions when to notify the registered nurse (RN) regarding blood sugars but lacked instructions when to hold any type of insulin or instruction on what to include in the notes when insulin was held. R1's record included the following documentation: -June 8, 2025, at 8:00 a.m., aspart held (no explanation why it was held), BG was 125; -June 18, 2025, at 8:00 a.m., Lantus was held (no explanation why it was held); -June 22, 2025, at 12:00 p.m., aspart was not administered (no explanation why it was held), BG was 117; -June 23, 2025, at 8:00 p.m.-Lantus held because R1 didn't eat, only drank, BG was 209; and -June 24, 2025, at 6:00 p.m., aspart not administered (no explanation why it was held), BG was 129. R1's medical record lacked documentation of specific resident instructions relating to administration of insulin and any resident-specific requirements relating to documenting medication administration. The record did not include specific reasons to hold any insulin or explanation why any insulin was held. SITE DOCUMENTATION On July 1, 2025, at 9:47 a.m., unlicensed personnel (ULP)-B placed needles on both insulin aspart and insulin Lantus, wiped the abdomen with an alcohol wipe and injected the aspart into the right side of the abdomen and completed the same process for the Lantus on the left side of the abdomen. ULP-B then documented the insulin administration by clicking the	01730		

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01730	Continued From page 18 "administered" box on the electronic health record (Residex) and made a note how much insulin was administered and what the BG was. R1's medical record lacked documentation of where insulin was administered. The manufacturers instruction for Lantus SoloStar pen dated August 2022, indicated injection sites included abdomen, thighs, and upper arms and to rotate injection sites with each dose to reduce the risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. The manufacturers instruction for insulin aspart revised February 2023, indicated the same information as the Lantus instruction. MEDICATION RECONCILIATION R1's Med Admin Summary dated July 2025, indicated the following duplicate medication: -acetaminophen 500 mg tablet, take two tablets by mouth every 6 hours as needed; -acetaminophen 500 mg tablet, take two tablets by mouth every 6 hours as needed for moderate pain (duplicate); -acetaminophen 325 milligram (mg) tablet, take two tablets every 4-6 hours as needed (different dose); -bacitracin 500 ointment, apply thin layer, do not use on newly burned area or deep puncture wounds unless directed by physician (topical antibiotic); -Neomycin, apply thin layer, do not use on newly burned area or deep puncture wounds unless directed by a physician (same medication as bacitracin); -cough/chest DM 20-200/20 ml (milliliter) syrup,	01730		

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01730	Continued From page 19 give 10 ml by mouth every 4 hours as needed for cough; -Robitussin, give two teaspoons (10 ml) by mouth every 4 hours as needed (same as cough/chest DM); -milk of magnesia 473 ml, give 15 ml by mouth once daily as needed for heartburn or constipation; and -milk of magnesia 400 mg/5 ml suspension, give 30 ml by mouth as needed (duplicate with different dose). During R1's medication and MAR review July 1, 2025, at 12:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A did not realize there were duplicates and after viewing R1's MAR, she acknowledged there were duplicate medications. She stated that occurred because the house standing orders (over the counter medications made available when needed) were included on the MAR. LALD/CNS-A said she would remove the duplicate medications on the MAR. During phone interview on July 2, 2025, at 11:25 a.m., LALD/CNS-A stated medication reconciliation was completed monthly with a pharmacist, then for as needed medications, she would call and order when needed. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident and ensure it would be current and updated. The plan would include the following: -documentation of specific resident instructions relating to the administration of medications; and -and resident-specific requirements relating to	01730		

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01730	Continued From page 20 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. The policy also read medication reconciliation would be completed when a licensed nurse, licensed health professional, or authorized prescriber was providing medication management. The licensee's 7.22 Medication & Treatment Record-Documentation & Refusal policy dated August 1, 2021, indicated the licensee would create and maintain a correct and accurate medication record for each resident receiving medication administration. The policy indicated if the medication administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	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	01760		

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01760	Continued From page 21 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 ensure medications were administered as ordered, timely, and followed appropriate medication administration procedures for one of one resident (R1) who received medication administration and management assistance. 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 had diagnoses including diabetes type 2, bipolar disorder (mood swings from mania to depression), mania with grandiosity, borderline personality disorder (mental health condition that affects the way people feel about themselves and others), and major depressive disorder. R1's Service Plan (Waiver)-Addendum to Contract dated July 1, 2025, indicated R1 received services including assistance with housekeeping, laundry, transfers, bathing, safety checks, dressing, toileting, behavior	01760		

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01760	Continued From page 22 management, blood glucose checks, and medication administration. During observation on July 1, 2025, between 8:53 a.m. and 9:50 a.m., unlicensed personnel (ULP)-B checked R1's blood glucose (BG) meter which read 180 mg/dL (milligrams per deciliter). ULP-B stated R1 had chocolate milk earlier in the morning but did not say when and did not have breakfast. ULP-B set up R1's oral medications then filled powdered polyethylene glycol powder (for constipation) below the line (filled at the line equaled 17 grams). ULP-B then put the powder into small cup of water. ULP-B grabbed R1's Lantus flex pen (slow acting insulin) and aspart flex pen (fast acting insulin). ULP-B dialed the Lantus flex pan to 20 units and aspart was dialed to 14 units per R1's medication administration record's (MAR) insulin sliding scale based on BG results. ULP-B grabbed a "Snack Pack" pudding, needles, and alcohol wipes and went to R1's room where they administered the oral medications with pudding. R1 then drank the water/polyethylene glycol powder. ULP-B placed needles on each flex pen without priming (process of removing any air bubbles by dialing two units and wasting it to ensure the most accurate dose) and administered the insulins. R1 wanted to go back to bed, and ULP-B helped R1 lay down and applied covers and left the room. At 10:53 a.m., ULP-B informed the surveyor that R1 was ready to get out of bed. It took R1 and ULP-B approximately 20 minutes to get dressed and transferred to wheelchair and brought to the dining room table for a meal. The manufacturers instruction for insulin aspart revised February 2023, indicated to inject insulin aspart subcutaneously (SQ) within 5-10 minutes before a meal.	01760		

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01760	Continued From page 23 MEDICATION ERROR R1's provider orders dated April 14, 2025, ordered the following medications: -Miralax (polyethylene glycol), dissolve 17 g (grams) into 4-8 ounces of liquid once daily; and -insulin aspart flex pen, inject 12 u (units) SQ with breakfast and 10 u SQ with lunch and dinner for blood sugar 149 mg/dL or less plus an additional 2 units of insulin for every 50 mg/dL. R1's Lantus order dated May 22, 2025, ordered Lantus insulin flex pen, inject 20 u SQ every morning and 24 units at bedtime. R1's MAR dated June 1 through 30, 2025, indicated the following instructions: -Polyethylene glycol, mix 17 g (measure with markings inside cap) in 4-8 ounces of liquid once daily; -insulin aspart was written the same as the providers order listed above; and -Lantus Solostar, inject 20 u SQ every morning and 24 u subcutaneously at bedtime. R1's medical record included the following documentation by ULP-E for Lantus insulin at 8:00 p.m.: -June 12, 2025, BG 283, 10 units given, "did not eat well" (24 u was the correct dose); -June 16, 2025, 10 u administered (24 u was correct dose); -June 17, 2025, 20 u given (24 u was the correct dose); -June 24, 2025, 10 u given (24 u was the correct dose); -June 30, 2025, 20 u given (24 u was the correct dose); and -July 1, 2025, 20 u given (24 u was the correct dose).	01760		

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01760	Continued From page 24 R1's medical record included the following documentation for aspart insulin: -June 3, 2025, at 12 p.m., BG 209, 12 u given (14 u was correct dose); -June 5, 2025, at 8 a.m., BG 165, 20 u given (14 u was correct dose); -June 16, 2025, at 6 p.m., BG 250, 14 u given (16 u was correct dose); -June 17, 2025, at 6 p.m., BG 256, 14 u given (16 u was correct dose); and -July 1, 2025, at 6 p.m., BG 200, 12 u given (14 u was correct dose). TRANSCRIPTION ERROR R1's Lantus order dated May 22, 2025, ordered to change the morning dose from 24 u to 20 u and keep the bedtime dose at 24 u daily. R1's Med Admin Summary dated June 2025, indicated the Lantus dose was changed from 24 u to 20 u at 8:00 a.m. on June 2, 2025, at 2:34 p.m. (approximately 11 days after the order was written). On July 1, 2025, at 10:00 a.m., ULP-B said they were not taught to prime the insulin flex pen, their process was to set the ordered dose on the flex pen dial while in front of the MAR then when they were ready to administer the insulin, the needles were put on and injected. The surveyor asked if the polyethylene glycol powder was poured below the indicated line, it was 17 grams, ULP-B stated yes. During interview on July 1, 2025, at 2:33 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated her understanding was the flex pen needed to be primed when using it for the first time, not for	01760		

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NEW HORIZON ASSISTED LIVING LLC	7119 GIRARD AVENUE NORTH BROOKLYN CENTER, MN 55430

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01760	Continued From page 25 every use and that was how her staff were trained. LALD/CNS-A demonstrated to the surveyor that the polyethylene glycol powder needed to be filled to the indicated line which was hard to see. On July 2, 2025, the surveyor attempted to reach ULP-E by phone at 9:44 a.m., 9:55 a.m., and 11:01 a.m., with no answer. The surveyor did not receive a return call by the time the survey concluded. During phone interview on July 2, 2025, at 11:25 a.m., LALD/CNS-A stated R1 was supposed to be receiving 24 u of Lantus at bedtime and would need to follow up with staff to ensure staff were administering the correct dose. On July 2, 2025, at 2:35 p.m., via electronic mail, LALD/CNS-A stated the Lantus order from May 22, 2025, was implemented same day and informed staff of the dose change via "snap message on Residex" but the change on the MAR was not reflected until June 2, 2025, an oversight on her part. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated August 1, 2021, indicated the RN has instructed the ULP in proper methods with respect to each resident to administer the medications and the ULP has demonstrated the ability to competently followed the procedures, specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. The licensee's 7.36 Insulin policy dated August 1, 2021, indicated insulin medications must be administered according to the prescribers' orders.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39171	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON ASSISTED LIVING LLC	7119 GIRARD AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01760	Continued From page 26 Medications always needed to be administered according to the "6 rights," right person, right medication, right time, right route, right dose, right chart/record to document that the medication was taken No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

New Horizon Assisted Living
7119 Girard Ave N
Brooklyn Center, MN 55430
Hennepin County
Parcel:

Phone:
samaya@newhorizonmn.com

License Info

License: 0042027

Risk:
License: -1
Expires on: 12/31/2023
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8044251063
Inspection Type: Full - Single
Date: 7/1/2025 Time: 10:16:21 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: Leftovers in refrigerator.
Comply By: 7/1/2025 Originally Issued On: 7/1/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Anna Bohnen. Copy of report reviewed on site with Sarah Amaya.

Domestic kitchen consists of tile floors, painted walls, wooden hollow-base cabinets, laminate counters and domestic equipment, including a dishwasher.

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 Rochester District Office inspection report number F8044251063 from 7/1/2025

Sarah Amaya

Michael DeMars,
Public Health Sanitarian III
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

New Horizon Assisted Living
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044251063
Inspection Type: Full
Date: 7/1/2025
Time: 10:16:21 AM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41.4 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Refrigerator at 41.0 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

New Horizon Assisted Living
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044251063
Inspection Type: Full
Date: 7/1/2025
Time: 10:16:21 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160.0 Degrees F.
Comment:
Violation Issued?: No