Electronically Delivered

August 29, 2025

Licensee
Beyond Senior Living
6281 Oakwood Road
Woodbury, MN 55125

RE: Project Number(s) SL28375017

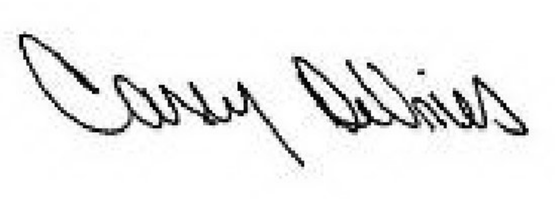
Dear Licensee:

On July 21, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 23, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	28375	A. BUILDING: _____ B. WING _____	R 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND SENIOR LIVING	6281 OAKWOOD ROAD WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY INITIAL COMMENTS SL28375017-1 On July 21, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 23, 2025. As a result of the follow-up survey, the licensee is in substantial compliance.	{0 000}		
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The	{0 340}		

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{0 340}	Continued From page 1 commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by:	{0 340}	Not reviewed during this survey.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius 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	{0 480}		

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{0 480}	Continued From page 2 contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of	{0 485}		

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{0 485}	Continued From page 3 Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during this survey.	
{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	{0 680}		

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{0 680}	Continued From page 4 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	{0 700}	Not reviewed during this survey.	
{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	{0 780}		

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{0 780}	Continued From page 5 sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in 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: Not reviewed during this survey.	{0 780}	Not reviewed during this survey.	
{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	{0 810}		

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{0 810}	Continued From page 6 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{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.	{0 970}		

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{0 970}	Continued From page 7 This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.	
{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 of the resident's reassessment. (e) For residents only receiving assisted living	{01620}		

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{01620}	Continued From page 8 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:	{01620}	Not reviewed during this survey.	
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey.	

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May 30, 2025

Licensee
Beyond Senior Living
6281 Oakwood Road
Woodbury, MN 55125

RE: Project Number(s) SL28375017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 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.

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

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

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $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
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,500.00**. 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

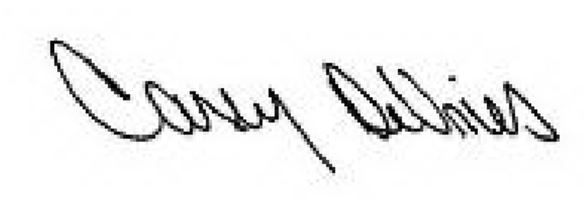
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28375017-0 On April 21, 2025, through April 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two resident(s); two receiving services under the Assisted Living Facility license. An immediate correction order was identified on April 22, 2025, issued for SL28375017-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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	28375	A. BUILDING: _____ B. WING _____	04/23/2025

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to meet the definition of an assisted living facility when the licensee had non-resident individuals with no assisted living contracts residing at the location. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's assisted living licensure effective date was February 25, 2025, with an expiration date of February 24, 2026. On April 21, 2025, at 11:22 a.m., during a tour of the facility basement, in a basement bedroom the surveyor observed a bed with linens, and a continuous positive airway pressure (CPAP) machine set up on a night stand next to personal effects such as creams, glasses cases, and over the counter eyedrops. In addition, the surveyor observed two large suitcases with clothing and personal items on top of the suitcases, as well as	0 130		

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0 130	Continued From page 5 multiple shopping bags full of additional personal items. The surveyor observed unlicensed personnel (ULP)-C in the basement bedroom wearing pajamas. On April 21, 2025, at 11:27 a.m., licensed assisted living director (LALD)-A stated the basement bedroom was used as a sleeping room for staff in between shifts. LALD-A stated the licensee had a period of time in which staff needed to work short additional shifts to ensure around the clock coverage, and the room was used to allow staff to rest between shifts. LALD-A stated at times, staff spent several consecutive days at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by	0 340		

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0 340	Continued From page 6 any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed April 5, 2023. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 1, 2023, the licensee received the results of the survey concluded on April 5, 2023. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was May 22, 2023. The licensee's results from the survey concluded	0 340		

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0 340	Continued From page 7 on April 5, 2023, included order numbers 0480, 0660, 0680, 0810, 0970, and 1650. On April 22, 2025, at 11:03 a.m., the surveyor requested the licensee's written plan of corrections from the previous survey concluded on April 5, 2023, from licensed assisted living director (LALD)-A. On April 22, 2025, at 11:55 a.m., the surveyor followed up on the previous request for the licensee's written plan of corrections from LALD-A. LALD-A stated they were still looking for that document, but they believed they had fixed all items from their previous survey. On April 22, 2025, at 11:57 a.m., LALD-A stated a new contract was not reissued after the licensee's previous licensing survey. On April 22, 2025, at 12:55 p.m., LALD-A stated they were unable to locate the licensee's written plan of corrections. Correction orders 0680 and 0970 were reissued. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed	0 480		

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0 480	Continued From page 8 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 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	0 480		

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0 480	Continued From page 9 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 April 22, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

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0 485	Continued From page 10 All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's contract dated October 2022 indicated three meals per day were included in the basic monthly	0 485		

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0 485	Continued From page 11 fee. R3's contract dated December 9, 2021, indicated three meals per day were included in the basic monthly fee. On April 23, 2025, at 12:25 p.m., licensed assisted living director (LALD)-A stated the licensee did not have an addendum to their contract for the purpose of subtracting the cost of meals if the resident wished to receive less meals per day from the base rate of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
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	0 680		

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0 680	Continued From page 12 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post the emergency plan prominently. 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: On April 21, 2025, at 11:13 p.m., the surveyor retrieved a copy of the licensee's EPP, which was pinned to the wall of the licensee's main living area. Licensed assisted living director (LALD)-A stated some of the licensee's EPP was posted on the wall, and other parts were on the computer. LALD-A stated there was no complete printed version. LALD-A stated they were responsible for the development of the EPP.	0 680		

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0 680	Continued From page 13 The licensee's Emergency Plan dated June 2, 2023, lacked evidence of the following required content: - documentation of an annual review of the EPP; - documentation of quarterly review of the licensee's missing resident plan; - documentation of an annual review of the licensee's all hazards risk assessment; - policies and procedures regarding at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - policies and procedures for the process of cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - development of policies and procedures based on the risk assessment; - development of policies and procedures for subsistence needs for staff and patients; - development of policies and procedures for tracking staff and patients; - development of policies and procedures that address the safe evacuation from the facility, including consideration of care/tx needs of evacuees; staff responsibilities; transportation; primary/alternate communication means with external sources of assistance; - development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - development of policies and procedures to address providing care/tx at alternate are sites under 1135 waiver; - documentation of the annual review of the communication plan; - the names and contact numbers of staff, entities providing services under agreement, residents' physicians, other facilities, volunteers;	0 680		

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0 680	Continued From page 14 - contact information for federal, state, tribal, regional & local EP staff, state licensing and certification agency, MN Office of Ombudsman for LTC and other sources of assistance; - methods for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care, and; - means to providing information about the facility's occupancy, needs, and its ability to provide assistance; - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - training and testing program; - emergency prep training program, and; - emergency prep testing requirements. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to	0 700		

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0 700	Continued From page 15 control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 22, 2025, at 7:19 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare medications for R2 using the licensee electronic medication administration record (EMAR). The licensee's EMAR was open on a laptop computer placed on a dining table adjacent to the licensee's kitchen directly visible to any residents or visitors in the dining area. At 7:32 a.m., after completing the setup of medications for R2, ULP-D walked away to administer the medications and left the computer monitor open and unattended. ULP-D returned to the unsecured computer at 7:50 a.m. On April 22, 2025, at 7:52 a.m., ULP-D stated they were trained to secure computer screens in between medication passes. ULP-D stated they made the mistake due to being out of their normal	0 700		

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	28375	A. BUILDING: _____ B. WING _____	04/23/2025

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BEYOND SENIOR LIVING	6281 OAKWOOD ROAD WOODBURY, MN 55125

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0 700	Continued From page 16 routine. On April 22, 2025, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated staff were trained to secure computer screens in between medication passes. The licensee's Privacy of Protected Health Information policy dated August 1, 2021, indicated the licensee shall protect the privacy of its resident's health information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
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 and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level 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	0 775		

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0 775	Continued From page 17 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 23, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. The door leading from the basement to the first floor had a chain style night latch lock on the first-floor side of the door. The main door to the facility was equipped with a double keyed deadbolt lock. Doors shall be readily openable from the egress side without the use of a key or special knowledge or effort. There are two doors that lead into the attached garage from the facility. Both doors are equipped with chain style night latch locks. The locks were installed at 6 feet from the finished floor. Door handles, pulls, latches, locks and other operating devices shall be installed 34 inches (864 mm) minimum and 48 inches (1219 mm) maximum above the finished floor. The north door of the two doors that lead from the facility into the attached garage had a lockable handle, a deadbolt with a thumb latch, and a chain style night latch lock installed on it. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 18 for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in 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 and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 780		

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0 780	Continued From page 19 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 23, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A. Survey staff asked LALD-A to initiate a test of the smoke alarms throughout the facility. Upon testing, it was found that the smoke alarm in resident room 2 was not interconnected, and only sounded locally inside of the resident room. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
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	0 810		

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0 810	Continued From page 20 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. 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:	0 810		

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0 810	Continued From page 21 On April 23, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. The fire evacuation diagrams incorrectly labeled the attached garage as an egress path. The attached garage is a higher hazard and is not an approved egress path. Exit plan diagrams must	0 810		

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0 810	Continued From page 22 be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for staff on the fire safety and evacuation plan. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills Audit", indicated evacuation drills were conducted on May 31, 2024, July 31, 2024, September 29, 2024, November 29, 2024, January 28, 2025, and March 15, 2025. The times of the drills indicated that no drills were conducted on third shift. LALD-A stated that third shift was allowed to come in during second shift and participate in fire drills so that residents didn't need to be woken up at night. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 970	Continued From page 23	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On April 22, 2025, at 2:08 p.m., licensed assisted living director (LALD)-A provided the surveyor with a digital master copy of the licensee's contract via email. Page 13 of the licensee's Assisted Living Contract under the section titled Indemnification, indicated the following:	0 970		

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0 970	Continued From page 24 "[Name of Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Name of Licensee] harmless from any claims or damages unless caused solely by negligence of [Name of Licensee]." On April 23, 2025, at 2:51 p.m., LALD-A stated they were cited on liability waivers during their previous licensing survey but did not realize new contracts needed to be reissued to residents to be in compliance with correction orders from the previous licensing survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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01620	Continued From page 25 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted October 3, 2022, to receive assisted living services. R2's Service Plan (Waiver) - Addendum to Contract, dated October 31, 2024, indicated R2 received assisted living services pertaining to activity assistance, ambulation, bathing assistance, bedmaking, behavior management, bathroom cleaning, decluttering of rooms,	01620		

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01620	Continued From page 26 dressing assistance, drinking assistance, escort assistance, fluid intake, grooming, housekeeping, incontinence care, laundry, linen change, meal assistance, medication administration, vital signs, nail care, safety checks, skin care, toileting, and transfer assistance. R2's record contained a 90-day assessment dated December 12, 2024. R2's next 90-day assessment was dated July 31, 2024, which indicated 154 days had lapsed between assessment dates. On April 22, 2025, at 3:46 p.m., clinical nurse supervisor (CNS)-B stated assessments were to be completed no later than 90-days from the previous assessment. CNS-B stated they set reminders on their electronic medication administration record (EMAR) to ensure assessments were completed on time, and did not know why they were not alerted when R2's assessment was due. On April 23, 2025, at 12:55 p.m., licensed assisted living director (LALD)-A stated during the time period in which the assessment was missed, the licensee was in between nurses, and the prior nurse employed by the license had set reminders up incorrectly for the oncoming nurse. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 21, 2025, at 11:22 a.m., the surveyor observed two boxes of Insulin Lispro Kwikpen 100u/ml and two boxes of Lantus Solostar 100u/ml belonging to R2 stored unsecured in the licensee's kitchen refrigerator. On April 22, 2025, at 7:08 a.m., to 7:50 a.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-D complete the morning medication pass. The licensee's medication cabinet was in the kitchen of the facility and consisted of two built in	01880		

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01880	Continued From page 28 cabinets, with one on top of the other mounted flush with the wall. The surveyor observed ULP-D left the medication cabinet unattended, with the key still in the lock, while administering morning medications, which resulted in the cabinet being accessible to any resident or visitors within the facility. On April 22, 2025, at 7:55 a.m., ULP-D stated they were trained to secure medication cabinets between medication passes, but did not do so as they were out of their normal routine. On April 22, 2025, at 8:01 a.m., the surveyor observed licensed assisted living director (LALD)-A attempting to secure the top medication cabinet but was unable to do so. LALD-A stated they would direct ULP-E to transfer all medications from the top cabinet, into the lower cabinet to ensure the medications were secured. While attempting to secure the medication cabinet, LALD-A stated they did not know how long the medication cabinet had been broken. On April 22, 2025, at 11:20 a.m., while attempting to complete an audit of the licensee's medication cabinet with ULP-E, the surveyor was able to access the licensee's lower medication cabinet without the use of a key. The door to the cabinet appeared to be locked, but was able to be pulled open with minimal effort by the surveyor when checking to see if the cabinet was locked. ULP-E attempted to secure this cabinet, but the lock on the licensee's medications cabinet was unable to engage in a way that secured the medication cabinet. On April 22, 2025, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated staff should be securing the medication cabinet, and keys should	01880		

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01880	Continued From page 29 be kept on staff at all times. Additionally, CNS-B stated R2's insulins should not be stored in the licensee's kitchen refrigerator and should be stored securely. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated medications are to be stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information and failed to ensure time sensitive medications were labeled with the date opened for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28375	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEYOND SENIOR LIVING	6281 OAKWOOD ROAD WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 30 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 22, 2025, at 7:39 a.m., during observation of a morning medication administration period with unlicensed personnel (ULP)-D, the surveyor observed two Humalog KwikPen insulin pens that belonged to R2 with no opened-on date. One of the undated pens had only 60 of 220 units of insulin remaining, which indicated the pen was in current use. On April 22, 2025, at 7:52 a.m., ULP-D stated they were trained on medication administration by the registered nurse, and understood that time sensitive medications needed to be labeled on the date of opening, but was unable to give a reason as to why the pens were not labeled. ULP-D stated they did not usually pass medications in the morning, but did so this morning. On April 22, 2025, at 3:44 p.m., clinical nurse supervisor (CNS)-B stated all time sensitive medications should be labeled upon opening. The manufacturer's instructions for Humalog Kwikpen date July 2023, indicated the insulin pen should not be use past the expiration date printed on the label or more than 28 days after first using the pen. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all prescription drugs are securely locked in	01890		

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01890	Continued From page 31 substantially constructed compartments according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, and medical, or nursing standards for one of one resident (R2) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 21, 2025, at 11:40 a.m., during a tour of the facility, the surveyor observed a hospital bed	02310		

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02310	Continued From page 32 in R2's room. R2's hospital bed had bed rails on both the left and right side of their bed, both of which were in the low position. R2 was admitted to the licensee on October 3, 2023, to receive assisted living services. R2's diagnoses included acute renal failure, hyperlipidemia, anxiety, hypertension, altered gait, hemorrhagic infarction, type 2 diabetes mellitus, and cerebral infarct. R2's most recent assessment dated March 11, 2025, completed by clinical nurse supervisor (CNS)-B, indicated R2 had a standard bed frame with no assistive devices for their bed. Additionally, the assessment indicated "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed". The assessment indicated R2 was disoriented to place and time and had memory deficiency. Due to R2's cognitive status, the surveyor did not interview R2 on the use of bed rails. R2's record lacked documentation of: - Purpose and intention of the bed rail; - Measurement of bed rail; - The resident's bed rail use/need assessment; - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On April 22, 2025, at 12:57 p.m., licensed assisted living director (LALD)-A stated the bed rails on R2's bed came with the bed when it was	02310		

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02310	Continued From page 33 delivered. LALD-A stated the bed rails were still functional and were able to be raised and lowered. LALD-A stated they had messaged R2's family to request they come and take the bed rails off R2's bed. On April 22, 2025, at 1:18 p.m., LALD-A provided a screenshot of a text chain with R2's responsible party dated October 17, 2024. The screen shot showed LALD-A requested R2's family to come take R2's side rails off the bed. There was no follow-up correspondence provided to the surveyor. On April 22, 2025, at 2:57 p.m., LALD-A stated R2's family had provided the hospital bed around a year ago. LALD-A stated R2 had never used the bed rails mounted to their hospital bed. LALD-A stated staff are directed to follow resident care plans, and the bed rails were not included in the resident care plan. LALD-A stated there were no directions instructing staff to not use the bed rails. On April 22, 2025, at 3:40 p.m., CNS-B stated they were not aware R2 had bed rails on their bed. CNS-B stated, "I never looked at their bed." Additionally, CNS-B stated going forward they would ensure bed rail assessments were being completed and they were aware of bed rail guidelines. The Licensee's Side Rail Use policy dated August 1, 2021, indicated the RN is responsible to ensure that the side rails in use are of a safe design and properly maintained and the need for side rails will be reassessed and documented as needed, but not less than every 90 days. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised	02310		

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02310	Continued From page 34 April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines;	02310		

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02310	Continued From page 35 - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.	02410		

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02410	Continued From page 36 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide residents the right to consideration of their privacy and personal property. This had the potential to affect all residnets and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 21, 2025, at 11:43 a.m., during a tour of the facility, the surveyor observed that the door of the shared bathroom on the main floor of the facility was disabled and unable to be closed. The strike plate on the door frame was stuffed with paper. The door latch had a Band-Aid which was used to secure the latch of the door so that the door latch was unable to engage into the strike plate on the door frame. Licensed assisted living director (LALD)-A stated the door was disabled out of concern for resident safety, and the bathroom was the primary bathroom used by residents and visitors. The licensee's Home Care Bill of Rights document indicated privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. No further information provided.	02410		

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02410	Continued From page 37 TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

DEPARTMENT OF HEALTH

Type: Full
Date: *04/22/25*
Time: 14:06:19
Report: 1036251092

Food and Beverage Establishment Inspection Report

Location:

Beyond Senior Living
6281 Oakwood Road
Woodbury, MN55125
Washington County, 82

Establishment Info:

ID #: 0038772
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512003082
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH ILLNESS LOG SENT TO ESTABLISHMENT AND EXPLAINED DURING INSPECTION.

Comply By: 05/05/25

4-500 Equipment Maintenance and Operation

4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

QUAT SANITIZER CONCENTRATION IN SPRAY BOTTLE WAS MEASURED AT 0 PPM. ENSURE TO MAINTAIN SANITIZER CONCENTRATION OF 200-400PPM.

Comply By: 05/05/25

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED SOME WOODEN SPOONS IN DRAWER THAT ARE USED FOR FOOD PREP. WOOD UTENSILS WERE REMOVED FROM KITCHEN.

Comply By: 04/21/25

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

QUATERNARY AMMONIA: = 0PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -8 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS ZACHARY MORTH. INSPECTION CONDUCTED IN PRESENCE OF ANGELINA SAM, THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED
WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- SANITIZER USE AND TEST KITS.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
Date: *04/22/25*
Time: 14:06:19
Report: 1036251092
Beyond Senior Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1036251092 of 04/22/25.

Certified Food Protection Manager: ANGELINA S. SAM

Certification Number: 32015 Expires: 06/03/28

Inspection report reviewed with person in charge and emailed.

Signed: _____
ANGELINA SAM
PERSON IN CHARGE

Signed: _____
Jeff Johanson