



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 11, 2026

Licensee
Skyblu Residential Services
8943 Dunbar Knoll North
Brooklyn Park, MN 55443

RE: Project Number(s) SL39509016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 21, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39509	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER SKYBLU RESIDENTIAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 8943 DUNBAR KNOLL NORTH BROOKLYN PARK, MN 55443		
(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: SL39509016-0 On May 18, 2026, through May 21, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; all of whom received services under the Assisted Living Facility license. An immediate correction order was identified on May 20, 2026, issued for SL39509016-0, 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	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,	0 480			

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0 480	Continued From page 2 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: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 19, 2026, 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	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 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	0 485			

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0 485	Continued From page 4 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 blank Assisted Living Contract dated 2021 included the following statement, "Subject to the Resident's needs, [the licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [the licensee] staff at the following times: 7:00 - 8:00 AM Breakfast 12:00 Noon - 1:00 PM Lunch 5:30 - 6:30 PM Dinner". The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee and lacked the option to opt out of the meal plan. On May 20, 2026, at 11:15 a.m., licensed assisted living director (LALD)-D stated the blank contract was used for all residents who resided within the facility. On May 20, 2026, at 11:22 a.m., LALD-D stated they were aware contracts could not include meals as part of the licensee's base fee. LALD-D stated they did not notice the writing within the contract which included meals as part of the base fee, and they were not aware that the licensee needed to provide an opt-out option if they included meals as part of their base fee. No further information was provided.	0 485			

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0 485	Continued From page 5	0 485			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-A, housing manager/unlicensed personnel (HM/ULP)-B).	0 650			

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0 650	Continued From page 6 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: CNS-C CNS-C was hired on October 19, 2020, under the licensee's former comprehensive license, and began providing assisted living services August 1, 2021. CNS-C was hired to provide oversight and supervision to ULP. CNS-C's personnel file included documents titled Assisted Living Minnesota Orientation Checklist Requirements signed January 24, 2020, and Comprehensive Home Care and Housing with Services Orientation / Annual Tracker dated October 20, 2020. The documents included the subject of home care orientation with the objectives of an overview of home care licensure and review of the home care services and providers scope of licensure. CNS-C's file lacked additional orientation when the licensee's new license for assisted living went into effect on August 1, 2021, of the following: - overview of assisted living statutes; and - review of types of assisted living services the employee would provide and the provider's scope of license. CNS-C's personnel file included performance evaluations completed October 20, 2022, and October 23, 2023, but lacked an annual	0 650			

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0 650	Continued From page 7 performance evaluation for the years 2024 and 2025. ULP-A ULP-A was hired on February 15, 2024, to provide assisted living services to residents. ULP-A's personnel file included a document titled Orientation Tracking dated February 10, 2024, which included "Overview of Home Care and HWS statues; Types of Services and Licensure". ULP-A's file lacked the following required orientation topics of an overview of assisted living statutes and review of types of assisted living services the employee would provide and the provider's scope of license. ULP-A personnel file included a performance evaluation dated May 17, 2024, but lacked an annual performance evaluation for the year 2025. HM/ULP-B HM/ULP-B was hired on February 26, 2024, to oversee day-to-day operations and to provide assisted living services. HM/ULP-B's personnel file included a document titled Orientation Tracking dated February 27, 2024, which included "Overview of Home Care and HWS statues; Types of Services and Licensure". HM/ULP-B's file lacked the required orientation topics of an overview of assisted living statutes and review of types of assisted living services the employee would provide and the provider's scope of license. HM/ULP-B's personnel file included HHA / Unlicensed Personnel Competencies Tracking Form dated February 29, 2024, which included the topics of continuous positive airway pressure	0 650			

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0 650	Continued From page 8 (CPAP) care, and oxygen. The licensee served residents who required these use of oxygen and CPAP. Neither of the topics were filled in with a date completed, if the practical test was passed, or a training initial or title, which indicated the topic was not covered during the training and competency evaluations. HM/ULP-B's file lacked documentation of a competency evaluation and training for CPAP and oxygen. HM/ULP-B's file included a Probationary Period Performance Evaluation 90 Day Review completed May 28, 2024. HM/ULP-B's file lacked an annual performance review for the year 2025. On March 19, 2026, at 2:29 p.m., HM/ULP-B stated they received training and completed a return demonstration on oxygen and CPAP with the nurse. HM/ULP-B also stated they received training on assisted living statues a long time ago. On May 20, 2026, at 8:33 a.m., ULP-A stated their nurse and supervisor trained them on assisted living statues and services they would provide. On May 20, 2026, at 10:58 a.m., licensed assisted living director (LALD)-D stated the nurse completed performance evaluations at 30 days, 90 days, and one year after hire. LALD-D stated they did not complete performance evaluations annually. On May 20, 2026, at 11:02 a.m., LALD-D stated they provided the required assisted living orientation training topics listed above with all employees. LALD-D stated they "mixed up" the wording on their forms when the licensee converted from a comprehensive home care provider to an assisted living facility and kept	0 650			

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0 650	Continued From page 9 some of the documentation stating it was home care. On May 20, 2026, at 11:06 a.m., during an interview with LALD-D and CNS-C, LALD-D verified HM/ULP-B's personnel file lacked a competency evaluation for CPAP and oxygen. LALD-D stated they could see the sheet was not marked, however, HM/ULP-B received the training and competency evaluations. CNS-C stated they trained HM/ULP-B and watched them perform the tasks of CPAP and oxygen. CNS-C stated they filled out a different competency evaluation form prior to filling out competency tracking form and they believed they missed marking HM/ULP-B's competency tracking form. CNS-C stated they misplaced the other competency evaluation forms. The licensee's Personnel Records policy dated August 1, 2021, indicated the following records were kept in the personnel record: - documentation of orientation; - performance reviews; and - competency evaluations. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated orientation topics would include, but not be limited to overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 and the types of assisted living services the employee would be providing based on the uniform checklist disclosure of services and the organization's category of licensure. The licensee's Delegation of Assisted Living Tasks policy dated August 1, 2021, indicated the clinician would have access to the staff members personnel files or other reports to determine the	0 650			

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0 650	Continued From page 10 level of competence prior to delegation of any task so that up-to-date information about current available staff and their competency is available to have sufficient information to determine the appropriateness of delegating tasks to meet the resident's needs and preferences. 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	0 680			

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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
0 680	Continued From page 11 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP titled Emergency Book reviewed on January 26, 2026, lacked evidence of the following required content: - substance needs for staff and residents; - procedures for tracking of staff and residents; - procedure for transportation during and evacuation; - policies and procedures for medical documents; - arrangements with other facilities which included signed agreements; and - roles under a waiver declared by secretary in accordance with section 1135. On May 20, 2026, at 10:34 a.m., licensed assisted living director (LALD)-D stated staff were to grab food from the pantry located in the facility's basement if there was an emergency. LALD-D stated they did not have documentation	0 680			

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0 680	Continued From page 12 in the EPP that addressed what food staff should pack or where the food was located if there was an emergency. LALD-D stated if an evacuation was needed, transportation would be provided by the licensee's company vehicle. LALD-D stated the EPP did not document that the company vehicle would be used for transportation. LALD-D stated the EPP did not address tracking of staff and residents however, if they did need to track staff and residents, they would use the chain of command with verbal communication of where people were located. LALD-D stated emergency medical documents were kept in a red binder and staff would take the binder if they needed to evacuate for the residents medical record. LALD-D stated the EPP did not address the medical documents. LALD-D stated they did not have memorandums of understanding with any of the locations listed to evacuate to. LALD-D stated they had a verbal understanding with the evacuation sites. LALD-D stated the EPP lacked roles under a waiver declared by secretary and stated they have not heard of the waiver. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations	0 680			

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0 680	Continued From page 13 Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 720 SS=E	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 720			

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0 720	Continued From page 14 The findings include: On May 19, 2026, at 9:59 a.m., via email, the surveyor sent a request for R1's medical record and to include prescriber's orders for any medication or treatment that was listed on the medication administration record (MAR). On May 20, 2026, at 8:44 a.m., via email, the surveyor sent a request for R2's medical record and to include prescriber's orders for any medication or treatment that was listed on the MAR. On May 20, 2026, at 2:43 p.m., the surveyor verbally requested prescriber's orders for R1and R2. Manager/unlicensed personnel (M/ULP)-F stated their system put all residents' orders together and the licensee had to go through them and separate them for the surveyor. On May 21, 2026, at 7:31 a.m., via email, the surveyor again requested prescriber's orders for R1and R2. On May 21, 2026, at approximately 8:40 a.m., during an interview, the surveyor verbally requested orders from clinical nurse supervisor (CNS)-C for R1 and R2. On May 21, 2026, at 9:06 a.m., the surveyor verbally requested prescriber orders from licensed assisted living director (LALD)-D for R1 and R2. On May 21, 2026, at 11:32 a.m., the surveyor again verbally requested prescriber's orders from LALD-D for R1 and R2. On May 21, 2026, at 1:17 p.m., the surveyor	0 720			

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0 720	Continued From page 15 asked why it was taking took so long to receive prescriber's orders. CNS-C stated they sent the orders that were requested. On May 21, 2026, at 1:26 p.m., LALD-D stated they were having issues getting the orders because the chain of orders were long. On May 21, 2026, at 1:34 p.m., the surveyor received R1's prescribers orders. R1's prescriber's orders showed a time stamp at the top indicating the licensee received a fax of the prescriber's orders on May 21, 2026, at 1:22 p.m. On May 21, 2026, at 1:51 p.m., the surveyor received R2's prescribers orders. R2's prescribers orders showed a time stamp at the top indicating the licensee received a fax of the prescriber's orders on May 21, 2026, at 5:11 a.m. On May 21, 2026, at 1:51 p.m., the surveyor inquired why it took so long for the surveyor to receive the prescriber's orders for R1 and R2. CNS-C deflected the question and stated they just sent the surveyor the items that were needed. The licensee's Clinical Record policy dated August 1, 2021, indicated a current clinical record shall be maintained for all residents. In addition, the licensee would retain the clinical record for at least five years or as otherwise required by state or federal law. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 720			

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0 775	Continued From page 16	0 775			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

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0 810	Continued From page 17 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 810			

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0 810	Continued From page 18 Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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 the assisted living contract did not include language waiving the	0 970			

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0 970	Continued From page 19 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Assisted Living Contract dated 2021 included the following sections which contained language waving the licensee's liability for health, safety, or personal property of a resident: - Miscellaneous Provisions: "The resident agrees that [the licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [the licensee] or its employees or agents. The resident hereby releases [the licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [the licensee] or its employees or agents."; and - Indemnification: "[the 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	0 970			

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0 970	Continued From page 20 [the licensee] harmless from any claims or damages unless caused solely by negligence of [the licensee]." On May 20, 2026, at 11:15 a.m., licensed assisted living director (LALD)-D stated the blank contract was used for all residents who resided within the facility. LALD-D stated they were aware the contract could not include language that waived liability. LALD-D stated they modified the contract, after a previous survey, to try to remove the language of liability but stated, "I can't seem to get it right." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060			

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01060	Continued From page 21 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident with an emergency relocation (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01060			

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01060	Continued From page 22 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 was admitted to the licensee on February 5, 2025, and began receiving assisted living services. R2's diagnoses included diabetes, anxiety, bipolar (mental health condition characterized by significant mood swings including manic episodes and depressive episodes), and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking). R2's Service Plan: Part 3 signed February 5, 2026, indicated R2 received assistance with medication management, delegated clinical monitoring, other delegated tasks, treatments, bathing, hygiene, dressing, housekeeping, meals, behavior management, and transportation. R2's progress note dated January 29, 2026, indicated R2 was taken to the hospital on January 29, 2026, due to emesis and refusal of care. R2's progress note dated February 2, 2026, indicated R2 returned from their hospitalization with medication changes. R2's medical record lacked evidence that the licensee provided an emergency relocation notice. On March 20, 2026, at 11:54 a.m., the surveyor requested R2's emergency relocation notice.	01060			

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01060	Continued From page 23 Clinical nurse supervisor (CNS)-C stated R2 was not in the hospital for three days. The surveyor inquired if that meant they did not provide R2 with an emergency relocation notice. CNS-C stated they would look for one. On March 21, 2026, at 8:35 a.m., CNS-C stated the licensee provided emergency relocation notices for residents who were hospitalized for more than three days. The surveyor explained the statute to CNS-C and CNS-C stated the licensee faxed the Office of Ombudsman for Long-Term Care (OOLTC) within three days. On March 21, 2026, at 1:32 p.m., licensed assisted living director (LALD)-D stated they did not have an emergency relocation notice for R2 because there was confusion with timing of issuing the notice and it was not completed. The licensee's Discharge and Transfers of Residents policy dated August 1, 2021, indicated in the event of an emergency relocation, the facility would, as soon as possible, provide a written notice of emergency relocation to the following: - the resident; - the resident's legal representative; - the resident's designated representative; - if the resident received home and community-based services, the resident's case manager; and - if the resident had been relocated and not returned to the licensee within four days, the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

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01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of 20 employees (unlicensed personnel (ULP)-F) was affiliated with the licensee's current health facility identification number (HFID#) 39509. 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:	01290			

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01290	Continued From page 25 ULP-F was hired on May 15, 2025, to provide assisted living services. ULP-F documented in R1's medical record on May 7, 2026. On May 19, 2026, at 11:01 a.m., the surveyor compared the licensee's staff list to the licensee's provided NETStudy 2.0 roster (web-based system used by the Minnesota Department of Human Services (DHS) to submit and process background study requests). The surveyor did not observe ULP-F on the NETStudy 2.0 roster for HFID# 39509. The surveyor inquired if ULP-F still worked for the licensee. Licensed assisted living director (LALD)-D stated ULP-F worked at the licensee's facility and other facilities of the parent company. The surveyor requested the licensee's parent company NETStudy 2.0 roster. On May 19, 2026, at 11:32 a.m., the surveyor received a NETStudy 2.0 roster for ULP-F verses the parent company's roster. The roster showed the following: - ULP-F was affiliated to HFID# 41011 on May 15, 2025; - ULP-F was affiliated to HFID# 36058 on May 19, 2026, during the survey; - ULP-F was affiliated to the licensee's HFID#39509 on May 19, 2026, during the survey. LALD-D stated they saw ULP-F was not affiliated to HFID# 39509 so they fixed it. LALD-D stated ULP-F was affiliated with a different facility of the parent company, and they believed they had affiliated ULP-F to the licensee. LALD-D stated in NETStudy 2.0 if you do not close the window after a period of time or if you do not hit complete the affiliation does not process and they believed this was what occurred with ULP-F.	01290			

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01290	Continued From page 26 The licensee's Recruitment and Hiring Policy dated April 19, 2024, indicated licensed and unlicensed staff who have not completed a fingerprint background study, the criminal background check would be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS. The policy did not address affiliating the background studies to the licensee's HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
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	01620			

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01620	Continued From page 27 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 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620			

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01620	Continued From page 28 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 8, 2024, and began receiving assisted living services. R1's diagnoses included chronic obstructive pulmonary disease (COPD), sleep apnea, anxiety, multiple sclerosis, positive hepatitis B antibody, and demyelinating disease. R1's Service Plan: Part 3 indicated R1 received assistance with medication administration, bathing, grooming, dressing, home management, socialization, meals, behavior monitoring, transportation, and treatments as of March 2026. R1's medical record included ongoing assessments dated April 8, 2025, September 25, 2025, December 19, 2025, and March 14, 2026, which indicated 170 days passed between the April 8, 2025, assessment and the September 25, 2025, assessment. On May 21, 2026, at 8:08 a.m., clinical nurse supervisor (CNS)-C stated they set their reminder for ongoing assessments to be completed at day 85, so they have a five-day grace period to complete them. CNS-C stated they did not know if they had another assessment for R1 between the April and September assessment. CNS-C stated if they had another assessment for R1 completed in that time frame they would provide the assessment to the surveyor. The surveyor did	01620			

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01620	Continued From page 29 not receive another assessment completed between April 2025 and September 2025 prior to the conclusion of the survey. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated an ongoing resident reassessment must be conducted by a registered nurse (RN) and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640			

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01640	Continued From page 30 the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to finalize a current written service plan that included a signature or other authentication by the facility and by the resident documenting an agreement on the services to be provided for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 8, 2024, and began receiving assisted living services. R1's diagnoses included chronic obstructive pulmonary disease (COPD), sleep apnea, anxiety, multiple sclerosis, positive hepatitis B antibody, and demyelinating disease. On May 19, 2026, at 9:54 a.m., the surveyor observed an oxygen concentrator in R1's room. R1's prescriber orders signed December 22, 2025, included oxygen 2 liters (L) via nasal cannula as needed (PRN) to keep oxygen saturation levels above 92 percent (%).	01640			

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01640	Continued From page 31 R1's Medication Administration Record (MAR) dated May 2026 included "Oxygen saturation monitoring Check saturation is running 3L/min [minute] and oxygen is over 90 % As needed Goal: Oxygen should be 90 -100 % if lower than 90 % call RN". R1's Uniform Assessment Tool Form dated March 14, 2026, indicated on March 14, 2026, changes were made to the service plan to include supplemental oxygen. R1's Service Plan: Part 3 signed February 8, 2026, indicated R1 received assistance with medication administration, bathing, grooming, dressing, home management, socialization, meals, behavior monitoring, transportation. The document had a handwritten portion that indicated in March 2026 ULP and registered nurse (RN)/licensed practical nurse (LPN) were to do a treatment and to see attached care plan. The document was not signed after the revision of the service plan. R1's Mental Health Care Plan last reviewed March 14, 2025, had a handwritten area that read, "See Addendum for oxygen therapy." There was not an additional addendum in R1's medical record that discussed oxygen therapy. In addition, the document was signed on January 13, 2025, and the document lacked a new signature from the resident or resident's representative when revisions occurred. On May 21, 2026, at 8:07 a.m., clinical nurse supervisor (CNS)-C stated they typically completed the nursing portion of the service plan and then manager/unlicensed personnel (M/ULP)-E would get information related to	01640			

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01640	Continued From page 32 financials. CNS-C stated the licensee obtained signatures from the residents or resident's representative with a change in services. CNS-C stated they may not have printed out a signature page for R1 to sign when the change occurred however, the licensee's normal process was to let the resident know about the change in service and obtain a signature. The licensee's Service Plan policy dated August 1, 2021, indicated the initial service plan and any revisions were signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the	01650			

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01650	Continued From page 33 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted to the licensee on February 8, 2024, and began receiving assisted living services. R1's diagnoses included chronic obstructive pulmonary disease (COPD), sleep apnea,	01650			

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01650	Continued From page 34 anxiety, multiple sclerosis, positive hepatitis B antibody, and demyelinating disease. R1's Service Plan: Part 3 indicated R1 received assistance with medication administration, bathing, grooming, dressing, home management, socialization, meals, behavior monitoring, transportation, and treatments as of March 2026, and the services were included in the rate. In addition, the service plan indicated the service descriptions were written on the care plans. R2 R2 was admitted to the licensee on February 5, 2025, and began receiving assisted living services. R2's diagnoses included diabetes, anxiety, bipolar (mental health condition characterized by significant mood swings including manic episodes and depressive episodes), and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking). R2's Service Plan: Part 3 signed February 5, 2026, indicated R2 received assistance with medication management, delegated clinical monitoring, other delegated tasks, treatments, bathing, hygiene, dressing, housekeeping, meals, behavior management, and transportation and the services were included in the rate. In addition, the service plan indicated the service descriptions were written on the care plans. R3 R3 was admitted to the licensee on May 11, 2026, and began receiving assisted living services.	01650			

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01650	Continued From page 35 R3's diagnoses included sleep apnea and kidney failure. R3's Service Plan: Part 3 dated May 11, 2026, indicated R3 received assistance with medication administration, socialization, home management, meals, behavior management and transportation and the services were included in the rate. In addition, the service plan indicated the service descriptions were written on the care plans. R1, R2, and R3's service plans lacked information on the fee for the services being provided. On May 21, 2026, at 8:07 a.m., clinical nurse supervisor (CNS)-C stated they typically completed the nursing portion of the service plan and then manager/unlicensed personnel (M/ULP)-E would get information related to financials. CNS-C stated the rate for the service was written on the rate sheet and licensed assisted living director (LALD)-D would have more information related to the resident's rates. On May 21, 2026, at 1:32 p.m., LALD-D stated the rate for the residents was listed on the resident's support plan. LALD-D stated the rates of all residents who resided at the facility were documented on their Department of Human Services (DHS) Customized Living Rates Worksheet. LALD-D stated they did not have a rate documented on any of the licensee's documents. LALD-D stated when they checked included in rate, it meant it was included on the support plan. The surveyor then inquired what it meant for the other box on the service plan located under the box for included in rate that read, "EW or other fee structure". LALD-D stated if that box was marked it would mean they were	01650			

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01650	Continued From page 36 elderly waiver or private pay. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include the following: - a description of the services to be provided; - the fees for services with frequency of each services; - the identification of the staff or categories of staff who would provide the services; - the schedule and methods of monitoring reviews or assessment of the resident; - the schedule and method of monitoring staff providing services; and - a contingency plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760			

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01760	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to administer medications as prescribed for one of four 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 8, 2024, and began receiving assisted living services. R1's diagnoses included chronic obstructive pulmonary disease (COPD), sleep apnea, anxiety, multiple sclerosis, positive hepatitis B antibody, and demyelinating disease. R1's Service Plan: Part 3 indicated R1 received assistance with medication administration, bathing, grooming, dressing, home management, socialization, meals, behavior monitoring, transportation, and treatments. On May 19, 2026, at 8:09 a.m., the surveyor observed housing manager/unlicensed personnel (HM/ULP)-B wash their hands, open the locked medication closet, apply gloves, obtain R1's medication administration record (MAR), and remove the preset medication planner.	01760			

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01760	Continued From page 38 HM/ULP-B stated they were going to count the medication to make sure it was the correct amount of medication in the medication planner. HM/ULP-B stated there were nine pills and placed the medication from the planner into a medication cup. The surveyor observed eight pills (seven medications) listed on the MAR which included: - vitamin D3 2000 units (u); - doxazosin 4 mg; - sertraline 100 mg; - sertraline 50 mg; - chlorthalidone 12.5 mg (half pill); - loratadine 10 mg, - gabapentin 800 mg; and - tizanidine 4 mg. HM/ULP-B then obtained other medications for R1 from the medication cart which included inhalers and nasal sprays. HM/ULP-B walked to R1 in a different location of the facility and told R1 they had their medication for them. The surveyor intervened and asked HM/ULP-B to stop administering the medication and to return to the medication cart. The surveyor inquired why they were administering nine pills when the MAR showed only eight were due for administration. HM/ULP-B stated one of the pills was broken but there were only eight medications. Upon further investigation, the surveyor and HM/ULP-B were able to determine there was an additional loratadine 10 mg pill in the medication planner. HM/ULP-B called the nurse, removed the extra loratadine, and then administered R1's medications. HM/ULP-B stated they verified medications by counting the number of pills in the medication planner against what was listed on the MAR. HM/ULP-B stated they did do the verification process with R1's medications however, they thought the half pill was broken off of another medication not that it was a different medication.	01760			

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01760	Continued From page 39 On May 21, 2026, at 8:17 a.m., clinical nurse supervisor (CNS)-C stated prior to ULP administering medications they receive training via EduCare (a training software program) and in person with them. CNS-C stated they ensure the ULP follows the rights of medication administration and complete a competency evaluation with the ULP. CNS-C stated staff were trained to count the medication in the planner and verify the number of pills with the MAR. CNS-C stated the MAR showed the number of pills that would be placed into the medication planner, and ULP were trained to stop the medication pass and clarify with the nurse if the counts were off and then they would come to the facility and see what was incorrect. CNS-C stated they investigated the incident noted above and they believed another ULP spilled one of the medication planner days and placed the extra loratadine back into Tuesday's morning's medications. The licensee's Medication Administration policy dated August 1, 2021, indicated residents of the licensee were entitled to the safe administration of medications by qualified personnel according to a written medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890			

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01890	Continued From page 40 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for three of five residents (R1, R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 May 19, 2026, at 9:16 a.m., the surveyor observed the licensee's locked medication closet which housed a locked medication cart. The surveyor observed the following expired medications: - acetaminophen 500 milligrams (mg) with an expiration date of August 1, 2025, for R4; - quetiapine 25 mg with an expiration date of July 31, 2025, for R1; - 23 lidocaine patches with an expiration date of April 16, 2025, for R2. Housing manager/unlicensed personnel (HM/ULP)-B stated if they notice an expired medication, they move the medication to the lower drawer of the medication cart and notify the	01890			

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01890	Continued From page 41 nurse. HM/ULP-B stated they check every medication expiration date prior to administration. On May 21, 2026, at 8:21 a.m., clinical nurse supervisor (CNS)-C stated that when they come in to do weekly medication set up, they review the medication cart for refills, and they review the medication cart every three months for expired medications. CNS-C stated when they review the medication cart for expired medications, they make a note for themselves on medications that are nearing the expiration date, and when medications expire staff place the expired medications in the bottom drawer of the medication cart. The surveyor reviewed the medications that expired and informed them the medications were not located in the bottom drawer of the medication cart. CNS-C stated they did not know why there were expired medications located in the other drawers of the medication cart. The licensee's Medication Administration policy dated August 1, 2021, indicated the licensed nurse was responsible for assessing medications to assure that all medications were current and ordered by the prescriber and to identify any expired or outdated medications, which would be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940			

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01940	Continued From page 42 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of two residents (R2) who received treatments. This practice resulted in a level two violation (a	01940			

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01940	Continued From page 43 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 to the licensee on February 5, 2025, and began receiving assisted living services. R2's diagnoses included diabetes, anxiety, bipolar (mental health condition characterized by significant mood swings including manic episodes and depressive episodes), and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking). R2's Service Plan: Part 3 signed February 5, 2026, indicated R2 received assistance with medication management, delegated clinical monitoring, other delegated tasks, treatments, bathing, hygiene, dressing, housekeeping, meals, behavior management, and transportation. R2's Treatment Plan: Addendum to Service Plan dated February 5, 2025, included the following: - blood glucose monitoring daily by the unlicensed personnel or nurse with supervision of the nurse; - notify the registered nurse (RN) with any concerns, change in condition, low blood sugar readings, and refusals. R2's Physician Admission Orders signed March	01940			

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01940	Continued From page 44 6, 2025, included "BS (blood sugar) monitoring/injection" for health. The order did not contain any further information on when blood glucose monitoring should be performed. R2's Additional Assessment Diabetes dated February 5, 2025, indicated R2 had a daily blood sugar check. R2's Medication Administration Record dated May 2026, included, "Blood Glucose test. Test 1 time a day before meals." The time scheduled was 8:00 a.m. R2 refused the blood sugar 11 times and received assistance nine times by unlicensed personnel (ULP). R2's individualized treatment management plan comprised of multiple documents lacked information on parameters for when ULP should contact the nurse related to blood glucose readings. On May 21, 2026, at 8:26 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained to notify them if "the blood sugar is 70 or 80 below 100 they need to let me know." CNS-C stated if the blood sugar reading was low, they encouraged the resident to drink, recheck the blood glucose, and if the blood glucose reading was still low, they would contact a prescriber. The surveyor inquired about when ULP should call for higher blood glucose readings. CNS-C stated it would be a high reading such as, 300 or 245. The surveyor asked again when the ULP should contact the nurse for a high blood glucose reading. CNS-C stated at 180 they would need to know. The surveyor inquired where the ULP would find this information. CNS-C stated it would be found in the treatment plan.	01940			

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01940	Continued From page 45 The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the RN would prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments. The plan would address the following: - type of service to be provided; - procedures for documenting treatments or therapies; - procedures for monitoring treatment or therapies to prevent possible complications or adverse reactions; - identification of treatment or therapy tasks delegated to ULP; and - procedures for notifying the RN or licensed health professional when a problem arouse related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced	01960			

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01960	Continued From page 46 by: Based on observation, interview, and record review, the licensee failed to transcribe treatment orders as prescribed for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 8, 2024, and began receiving assisted living services. R1's diagnoses included chronic obstructive pulmonary disease (COPD), sleep apnea, anxiety, multiple sclerosis, positive hepatitis B antibody, and demyelinating disease. R1's Service Plan: Part 3 indicated R1 received assistance with medication administration, bathing, grooming, dressing, home management, socialization, meals, behavior monitoring, transportation, and treatments as of March 2026. In addition, the service plan indicated the service description was written on the care plans. R1's Home Health Aide Care Plan dated January 13, 2025, included a section titled Vital Signs: P [pulse], BP [blood pressure], Temp [temperature], O2Sat (sic) [oxygen saturation]. The document did not include information related to R1's	01960			

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01960	Continued From page 47 oxygen. R1's Mental Health Care Plan last reviewed March 14, 2025, read, "See Addendum for oxygen therapy." There was not an additional addendum in R1's medical record that discussed oxygen therapy. On May 19, 2026, at 9:54 a.m., the surveyor observed an oxygen concentrator in R1's room. R1's prescriber orders signed December 22, 2025, included oxygen 2 liters (L) via nasal cannula as needed (PRN) to keep oxygen saturation levels above 92 percent (%). R1's Medication Administration Record (MAR) dated May 2026 included "Oxygen saturation monitoring Check saturation is running 3L/min [minute] and oxygen is over 90 % As needed Goal: Oxygen should be 90 -100 % if lower than 90 % call RN". The MAR indicated R1 had not used their oxygen in the month of May. In addition, R1's oxygen was not transcribed on the MAR as prescribed. On May 21, 2026, at 1:57 p.m., the surveyor inquired why R1's order was not transcribed as prescribed. Clinical nurse supervisor (CNS)-C stated, "it was a typo error." The licensee's Prescriber's Orders policy dated August 1, 2021, indicated the registered nurse (RN) was responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01960			

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01960	Continued From page 48	01960			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain a treatment order that contained the required content 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 to the licensee on February 5, 2025, and began receiving assisted living services. R2's diagnoses included diabetes, anxiety, bipolar (mental health condition characterized by	01970			

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01970	Continued From page 49 significant mood swings including manic episodes and depressive episodes), and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking). R2's Service Plan: Part 3 signed February 5, 2026, indicated R2 received assistance with medication management, delegated clinical monitoring, other delegated tasks, treatments, bathing, hygiene, dressing, housekeeping, meals, behavior management, and transportation. In addition, the service plan indicated the service descriptions were written on the care plans. R2's Treatment Plan: Addendum to Service Plan dated February 5, 2025, included the following: - blood glucose monitoring daily by the unlicensed personnel or nurse with supervision of the nurse; - notify the registered nurse (RN) with any concerns, change in condition, low blood sugar readings, and refusals. R2's Medication Administration Record dated May 2026, included, "Blood Glucose test. Test 1 time a day before meals." The time scheduled was 8:00 a.m. R2 refused the blood sugar 11 times and received assistance nine times by unlicensed personnel (ULP). R2's Physician Admission Orders signed March 6, 2025, included "BS (blood sugar) monitoring/injection" for health. The prescriber's order lacked the following required content: - frequency of the treatment; - timing of the treatment; - target blood glucose range; and - type of blood glucose test to be performed.	01970			

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01970	Continued From page 50 On May 21, 2026, at 1:17 p.m., clinical nurse supervisor (CNS)-C stated the prescriber order listed above was R2's blood glucose order. The surveyor inquired if they clarified the missing content from the blood glucose order with the prescriber. CNS-C stated they contacted the prescriber and verbally clarified the order. CNS-C stated they were to perform blood glucose monitoring on R2 once per day. The surveyor requested documentation of the verbal order they received for R2's blood glucose monitoring. The surveyor did not receive the order prior to the conclusion of the survey. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse (RN) or licensed health professional would obtain orders or prescriptions for all treatment and therapies. The order would include the following elements: - resident name - description of the treatment or therapy to be provided; - frequency; and - other pertinent information. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated the licensee would provide all medically delegated services under an authorized prescriber's orders. In addition, verbal orders may be accepted by a nurse who records and signs the order, than forwards it to the prescriber for signature no later than seven days after the receipt of the verbal order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			

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02310	Continued From page 51	02310			
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 provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R2) who utilized consumer bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 18, 2026, at approximately 1:40 p.m., during the entrance conference, the surveyor inquired if the licensee conducted bed rail assessments. Clinical nurse supervisor (CNS)-C stated no residents at the facility had a bed rail. On May 20, 2026, at approximately 9:55 a.m., during a resident interview, the surveyor observed a consumer bed rail on the right side of R2's bed securely attached. The device was white and black. The upper portion of the bed rail was U	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39509	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER SKYBLU RESIDENTIAL SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 8943 DUNBAR KNOLL NORTH BROOKLYN PARK, MN 55443			
(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
02310	Continued From page 52 shaped with an additional U shape extending from the side of the bed rail. The bed rail was placed under the mattress with a strap to keep the device secure. The surveyor was unable to view any identifying manufacturer information. R2 was admitted to the licensee on February 5, 2025, and began receiving assisted living services. R2's diagnoses included diabetes, anxiety, bipolar (mental health condition characterized by significant mood swings including manic episodes and depressive episodes), and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking). R2's Service Plan Part 1 signed February 5, 2026, indicated R2 received assistance with medication management, delegated clinical monitoring, other delegated tasks, treatments, bathing, hygiene, dressing, housekeeping, meals, behavior management, and transportation. R2's ongoing assessment dated April 7, 2026, included a bed safety section which indicated the following: - R2 used a regular bed; and - the bed safety zone assessment was not applicable, either R2 had no bed rails in use or had portable bed rails that were installed on a consumer bed. R2's record included a Side-Rail Use Assessment Form dated February 5, 2025, and indicated the following: - a physical and cognitive assessment as they pertained to bed rails;	02310			

Minnesota Department of Health

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02310	Continued From page 53 - under recommendations for bed rails "none" was circled verses right, left, or bilateral; - interventions of providing frequent staff monitoring at night and verbal reminders to use the call bell; - side rails were indicated and served as an enabler to promote independence; - R2 expressed a desire to have bed rails raised while in bed; - R2 used bed rails due to hip pain and discomfort; - bed rails were securely attached (the question was not filled in by the assessor); - R2 received a risk and benefit related to bed rails; - the bed rail did not impede on R2's freedom of movement; and - the bed rail did not preclude R2's body movement. R2's bed rail assessment lacked the following required information: - the type of bed rail used; - if the bed rail was installed per manufactures' guidelines; - a physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation; and - if the United States Consumer Product Safety Commission (CSPC) was checked for recalls on R2's bed rail. R2's record lacked the manufacturer's guidelines for R2's bed rail and lacked evidence the registered nurse completed a bed rail assessment at least every 90 days. On April 20, 2026, at 10:22 a.m., CNS-C and licensed assisted living director (LALD)-D assisted the surveyor to lift the bed to look for an	02310			

Minnesota Department of Health

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02310	Continued From page 54 identifying sticker. The surveyor was unable to locate any identifying sticker to show the product number, make, model, or serial number of the device. The surveyor inquired if CNS-C knew the make or model of the device. CNS-C stated no. On May 20, 2026, at 12:26 p.m., CNS-C stated bed rail assessments were completed when the resident initiates a bed rail and with a change of condition in the resident. On May 20, 2026, at 12:48 p.m., the surveyor inquired why CNS-C stated the licensee did not have a resident with a bed rail during the entrance conference. CNS-C stated they were thinking of the bed rails designed for hospital beds and they considered R2's device a grab bar. CNS-C stated they did not know the make or the model number of the bed rail that R2 used. The surveyor inquired if the licensee checked for recalls on bed rails. CNS-C stated they had not checked the CSPC website to see if the bed rail had been recalled and asked, "I am supposed to check it?" CNS-C stated the bed rail assessment used above was the same used for any resident who would come to the facility and require a bed rail. CNS-C stated it was a typo error that they circled "none" for recommendations of whether to use bed rails when they should have circled right. CNS-C stated they answered the majority of questions on the assessment and missed the question if the bed rails were securely attached. On May 20, 2026, at 1:01 p.m., program manager/unlicensed personnel (PM/ULP)-E stated the licensee purchased the bed rail from Amazon. The surveyor asked them to print off the information on the bed rail. On May 20, 2026, at 1:14 p.m., the surveyor	02310			

Minnesota Department of Health

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02310	Continued From page 55 received a document showing the bed rail was the Xalirium bed rail manufactured by FoShan Koociri Health Technology Co. LTD. Model number KCR-S205-A. On May 20, 2026, at 1:34 p.m., the surveyor reviewed CSPC and did not observe the bed rail listed above to be recalled. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated May 4, 2026, "Unlike hospital beds, there is no current published guidance related to portable bed rails used on non-hospital style beds ("consumer beds"), so licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The FAQ also 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, it 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	02310			

Minnesota Department of Health

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02310	Continued From page 56 - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's Side Rail Use policy dated August 1, 2021, indicated before implementing side rails for a resident the RN would conduct a side rail assessment that included the following: - level of mobility; - level of consciousness; - level of cognition; - presence of orthostatic hypotension; and - vision. In addition, the resident or the resident representative would receive education related to bed rail. The bed rail would be reassessed and documented on as needed but not less than every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

SkyBlu Residential Services
8943 DUNBAR KNOLL NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39509

Risk:
License:
Expires on:
CFPM: Latia C. Castilleja
CFPM #: 117979; Exp: 07/13/2026

Inspection Info

Report Number: F8044261151
Inspection Type: Full - Single
Date: 5/19/2026 Time: 9:26:25 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.12A *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

COMMENT: Unable to locate stem thermometer.

Comply By: 5/20/2026 Originally Issued On: 5/19/2026

! New Order: 7-200 Toxic Supplies and Applications

7-204.11 *Priority Level: Priority 1 CFP#: 28*

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT: Fabuloso used to sanitize counters is not safe for food contact surfaces.

Chlorine spray provided while on site.

Comply By: 5/19/2026 Originally Issued On: 5/19/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Ashely Crews. Inspection report reviewed on site with

Domestic kitchen consists of laminate floors, wooden hollow base cabinets, granite counters, tile walls, textured ceilings and domestic equipment.

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 F8044261151 from 5/19/2026

Latia Castilleja

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

SkyBlu Residential Services
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F8044261151
Inspection Type: Full
Date: 5/19/2026
Time: 9:26:25 AM

Food Temperature: Product/Item/Unit: Hot dogs; Temperature Process: Cold-Holding

Location: Refrigerator 1 at 38.7 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Refrigerator 1 at 38.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk; Temperature Process: Cold-Holding

Location: Refrigerator 2 at 40.1 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Refrigerator 2 at 39.0 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	Inspection Info
SkyBlu Residential Services	Report Number: F8044261151
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 5/19/2026
	Time: 9:26:25 AM

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

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39509016-0	Date: 5/20/2026
Facility Name: SKYBLU RESIDENTIAL SERVICES	
Facility Address: 8943 DUNBAR KNOLL NORTH BROOKLYN PARK, MN 55443	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: Two separate smoke alarm systems were installed, a hardwired system and a wireless alarm, but each separate system was not interconnected. The hardwired smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The posted evacuation floor plans failed to provide identification for each resident room.

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

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.

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

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

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

Comments: Licensed assisted living director (LALD)-D stated no training was provided for staff.

5. 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-D stated no resident training was provided.