



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 22, 2026

Licensee
Aspen Homes
9508 Upton Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL35930016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 19, 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:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - \$1,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER ASPEN HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444			
(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: SL35930016-0 On August 17, 2026, through August 19, 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 (5) residents; all whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) for three of three residents (R3, R4, R5). 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: On August 17, 2026, at 10:45 a.m., during the	0 430			

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0 430	Continued From page 2 entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B stated the licensee had a census of five (5) residents. R3 R3 was admitted for services on July 30, 2026. On August 18, 2026, at 8:45 a.m., the surveyor met R3 outside while R3 was smoking in front of the garage. The surveyor completed a short interview with R3. R4 R4 was admitted for services on July 23, 2026. Between August 17, 2026, through August 19, 2026, at various times, the surveyor observed R4 enter and exit his bedroom numerous times. R5 R5 was admitted for services on April 8, 2026. On August 18, 2026, at 9:06 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R5. R3, R4, and R5's resident records included a "Statement of Home Care Services Comprehensive Home Care Provider," signed on July 30, 2026, July 23, 2026, and April 8, 2026, respectively. R3, R4, and R5's records lacked evidence that they were provided with the licensee's UDALSA related to the licensee's assisted living facility license. On August 18, 2026, at 1:50 p.m., CNS-B stated with help from house manager/ULP (HM/ULP)-C, they went over the assisted living contract with R3 and R4. When the surveyor asked if they	0 430			

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0 430	Continued From page 3 provided the UDALSA, CNS-B was unsure what the surveyor was talking about. CNS-B confirmed they had provided the Statement of Home Care Services to R3 and R4. On August 19, 2026, at 10:30 a.m., CNS-B was shown the UDALSA and CNS-B verbalized she did not provide that document to R3 and R4. On August 19, 2026, at 2:07 p.m., CNS-B stated she had gone over admission paperwork with R5 as well so R5 would have received the same contract and Statement of Home Care Services. The licensee's 1.04 Uniform Disclosure of Assisted Living Services & Amenities policy, undated, indicated the licensee would provide a UDALSA to prospective residents prior to signing an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult	0 550			

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0 550	Continued From page 4 Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 17, 2026, at 12:13 p.m., during posting review, the surveyor observed a bulletin board up propped up against the wall on the floor of the dining room area. Although the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center (MAARC) were posted, the postings lacked the facilities' grievance procedure, and the name, telephone number and email contact information for individuals who were responsible for handling	0 550			

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0 550	Continued From page 5 resident grievances. On August 17, 2026, at 3:10 p.m., house manager/unlicensed personnel (HM/ULP)-C attempted to locate the grievance procedure with clinical nurse supervisor (CNS)-B. CNS-B stated the grievance procedure must have fallen off the bulletin board when the board fell down. The licensee's Grievance Policy dated May 13, 2026, indicated the licensee's grievance procedure but did not indicate whether the licensee would post the grievance procedure in a conspicuous place. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660			

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0 660	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a baseline TB screening that included a two-step tuberculin (TST) skin test or other evidence of TB testing such as IGRA (a blood test), and results kept in each employee file for three of four employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated May 5, 2026, indicated the facility was at a low risk for TB transmission. The assessment indicated all staff required annual TB screening. ULP-D On August 18, 2026, at 9:06 a.m., the surveyor observed ULP-D administer oral medication to R5. ULP-D was hired on September 11, 2023, to provide direct care and services to residents.	0 660			

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0 660	Continued From page 7 ULP-D's employee record included an Employee TB screening form dated September 11, 2024, and September 8, 2025, which indicated ULP-D never had a TST before or been in contact with a person known to have active tuberculosis. ULP-D's record also included a negative chest x-ray dated July 3, 2023. ULP-E ULP-E was hired on June 18, 2026, to provide direct care and services to residents. ULP-E's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated June 1, 2026, indicating ULP-E never had a positive reaction to a TB skin test or blood test nor had a TB skin test completed the past 12 months. ULP-E's record also included an Employee TB Screening form dated June 18, 2026, which indicated ULP-E had never been in contact with a person known to have active TB. ULP-E's record lacked evidence testing for TB. On August 18, 2026, at 1:12 p.m., clinical nurse supervisor (CNS)-B provided the surveyor a photo of ULP-E's negative chest x-ray dated June 1, 2026. ULP-F ULP-F was hired on July 31, 2026, to provide direct care and services to residents. ULP-F's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated August 1, 2026, indicated ULP-F never had a positive reaction to a TST or TB blood test before or had a TST completed in the past 12 months. ULP-F's record included a negative chest x-ray dated August 3, 2026.	0 660			

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0 660	Continued From page 8 During phone interview on August 19, 2026, at 1:09 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she gave staff the option to choose either the blood test or the chest x-ray but it was up to the staff person's provider. LALD/RN-A stated she was not aware of the correlating documentation required with the chest x-ray. The licensee's 8.16 Tuberculosis Screening policy, undated, indicated staff whose essential job functions require work within the same air space of residents would be screened and tested for tuberculosis prior to the staff being exposed to residents. The policy also indicated new staff would have the TB blood test or a two-step TST conducted and documented. TB screening results would be kept in each employee medical file. The policy did not have chest x-ray procedures. The Minnesota Department of Health TB FAQs, last updated on June 5, 2026, indicated: "A CXR alone is not acceptable documentation. You either need: documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and a CXR with provider evaluation after that date or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

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0 680	Continued From page 9 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z and post emergency exit diagrams on each floor. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

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0 680	Continued From page 10 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 August 17, 2026, at 11:58 a.m., during facility tour with clinical nurse supervisor (CNS)-B, the surveyor observed a two-level home with a basement. There were three occupied bedrooms on the upper level and two occupied rooms on the lower level. The main level included a kitchen and dining room. The surveyor observed an exact exit diagram (which did not match any level of the facility) posted on the wall of the main floor dining room and another posted by the lower-level glass patio door. The upper level where three residents resided did not have exit diagram posted. The licensee's EPP last reviewed on January 2, 2026, lacked the following required content: -documentation of quarterly missing resident plan review; -arrangement with other facilities, lacked direction of where residents would relocate to; -names and contact information-communication plan missing two current residents; and -testing requirements-emergency prep training and testing. During phone interview on August 18, 2026, at 9:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they reviewed the missing resident plan monthly and documentation of those reviews would be within the EPP binder. The surveyor was unable	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 to locate the missing resident plan, so the surveyor asked the clinical nurse supervisor (CNS)-B to help locate the missing resident plan. On August 18, 2026, at 11:33 a.m., via email, the licensee (email did not identify themselves when responding to questions) provided their "3.13 Assisted Living with Dementia Care Wandering and Elopement" policy which included a missing resident/elopement procedure (was not originally included in the EPP binder). The licensee also indicated they completed monthly resident monitoring which was documented for each resident except for the two most recent admitted residents and said that documentation was part of their monthly missing resident plan review. On August 19, 2026, at 12:39 p.m., via email, the licensee provided an attached mock survey they completed December of 2025 to all staff. The document indicated the scenario was for snow and wind alert with the potential power outage. The rest of the form included space for staff to sign and date they participated in that exercise but it was left blank. The surveyor then requested documentation of which staff attended and an analysis of the exercise completed. On August 19, 2026, at 2:02 p.m., CNS-B stated they were unable to locate documentation of completing the mock exercise as requested. The licensee's 1.01 Organizational Approval and Review and Distribution Plan policy dated September 1, 2022, indicated the plan and procedures are reviewed at least annually or whenever new information or lessons learned necessitated a change. Corresponding policies and procedures would be reviewed and updated as applicable.	0 680			

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0 680	Continued From page 12 The licensee's 4.01 Training, Exercises, and Testing policy dated September 1, 2022, indicated the licensee's staff would participate in a full-scale exercise that was community-based, or when a community-based exercise was not accessible, an individual, facility-based tabletop exercise. The licensee would also conduct an additional annual exercise that may include a second full-scale exercise that is community-based or individual, facility-based; or a tabletop exercise, or a mock disaster drill. Exercises would be documented. Following all exercise events, staff would be given an opportunity to provide feedback on the accuracy and effectiveness of established policies, the emergency plan and implementing procedures. Minnesota Administrative Rule 4659.0100 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 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775			

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0 775	Continued From page 13 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 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 August 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790			

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0 790	Continued From page 14 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; 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 August 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=I	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 15 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. 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 August 18, 2026, the surveyor toured the facility with housing manager/unlicensed personnel (HM/ULP)-C. The following was observed. In resident room 4, the egress window failed to open when HM/ULP-C attempted to open it. HM/ULP-C stated that the resident had	0 800			

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0 800	Continued From page 16 damaged it as well as had noticeable wood decay. A non-operational emergency escape and rescue window (egress window) can delay access to safe evacuation of staff, residents, and visitors in the event of a fire. The egress window is a secondary path of egress and shall be maintained as such. The egress window is part of the life safety system of the building and allows the residents to escape and emergency personnel to enter. TIME PERIOD FOR CORRECTION: Immediate	0 800			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810			

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0 810	Continued From page 17 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 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 August 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810			

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0 970	Continued From page 18	0 970			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents (R3, R4). 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: R3 R3 was admitted for services on July 30, 2026. On August 18, 2026, at 8:45 a.m., the surveyor met R3 outside while R3 was smoking in front of the garage. The surveyor completed a short interview with R3. R4	0 970			

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0 970	Continued From page 19 R4 was admitted for services on July 23, 2026. Between August 17, 2026, through August 19, 2026, at various times, the surveyor observed R4 enter and exit his bedroom numerous times. R3 and R4's Assisted Living Contract signed on July 30, 2026, and July 23, 2026, respectively, included the following language waving the licensee's liability for health, safety, or personal property of a resident: -Indemnification: "[Licensee name] 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 [licensee name] harmless from any claims or damages unless caused solely by the negligence of [licensee name]. On August 18, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-B stated with help from house manager/unlicensed personnel (HM/ULP)-C, they went over the assisted living contract with R3 and R4. During phone interview on August 19, 2026, at 1:09 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she was aware of facility waiver of liability and stated they had removed it from the contract already. LALD/RN-A then stated CNS-B did not utilize the updated contract for R3 and R4. The remaining residents should have the updated contract. On August 19, 2026, at 2:07 p.m., CNS-B stated she had gone over admission paperwork with R5 as well so R5 would have received the same contract as R3 and R4. The surveyor requested to review R2's assisted living contract (R2 was	0 970			

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0 970	Continued From page 20 admitted for services on October 5, 2022) and CNS-B confirmed that R2's contract had the exact same verbiage as R3 and R4. The licensee's 1.05 Signing an Assisted Living Contract policy, undated, indicated the licensee would review and sign the assisted living contract with the prospective resident and/or responsible person and answer any questions they may have. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is 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	01060			

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01060	Continued From page 21 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 to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident had been relocated and had not returned to the facility within four days, with all required content after an emergency relocation for one of one resident (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).	01060			

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01060	Continued From page 22 The findings include: R2 was admitted for services on October 15, 2023, and had diagnoses including bipolar disorder, alcohol dependence, drug abuse, in remission, and post-traumatic stress disorder. R2's Master Care Plan last updated on May 8, 2026, indicated R2 received assistance with medication administration, arranging transportation, housekeeping, and behavior management. R2's Resident Notes-One Resident written by licensed assisted living director/registered nurse (LALD/RN)-A on May 30, 2026, at 11:05 a.m., indicated R2 became increasingly agitated and anxious breaking items within the facility. Despite staff de-escalation attempts, there were concerns for R2's safety and the safety of others, they contacted emergency medication services where R2 was transported to the hospital for a mental health evaluation and treatment as needed. On August 17, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-B provided their current resident roster and stated R2 was sent to the hospital on May 30, 2026, and had not returned from treatment yet. On August 17, 2026, at 10:39 a.m., the surveyor reached out to the regional ombudsman via email to verify if they received an emergency relocation notice around the time of May 30, 2026. At 12:53 p.m., the regional ombudsman replied via email indicating they did not see any emergency relocation notices received for that time. On August 17, 2026, at 1:10 p.m., CNS-B	01060			

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01060	Continued From page 23 provided the surveyor R2's signed bed hold form completed on May 30, 2026, when asked if R2 received their emergency relocation notice. On August 17, 2026, at 2:10 p.m., via email, the licensee emailed the surveyor R2's emergency relocation notice and indicated that the notice was faxed to OOLTC, but CNS-B was unable to locate the fax confirmation page. The notice did include a note for staff to fax the notice and keep a copy for R2's file. R2's record included a "Notice of Emergency Relocation" dated May 30, 2026, which included: - the reason for relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); - if known and applicable, the approximate date 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 - a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the residents may submit an appeal, which was provided to R2 and R2's designated representative. R2's record lacked evidence that the above written notice was delivered to the OOLTC when the resident had been relocated and had not returned to the facility within four days. During exit conference on August 19, 2026, at	01060			

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01060	Continued From page 24 2:20 p.m., LALD/RN-A stated they could not provide evidence that they submitted the emergency relocation notice to OOLTC. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated the licensee may remove a resident in an emergency if necessary due to a resident's urgent medical needs or imminent risk the resident poses to the health or safety of another resident or staff member. An emergency relocation was not a termination. In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of the Emergency Relocation to the following: -the resident; -the resident's legal representative; -if the resident receives home and community-based services, the resident's case manager; and -if the resident had been relocated and not returned to facility within four (4) days, the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental	01530			

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NAME OF PROVIDER OR SUPPLIER ASPEN HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444		
(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
01530	Continued From page 25 illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received two hours of mental illness and de-escalation training within the first 120 working	01530			

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01530	Continued From page 26 hours of employment for supervisors of direct care staff as required for one of one supervisor (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 17, 2026, at 10:45 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated they were responsible for all the licensee's employee orientation requirements for the licensee. LALD/RN-A also stated they provided one-on-one training using modules and policies and confirmed competency with quizzes. The licensee's Current Client Roster: Comprehensive (144A) with as of date August 17, 2026, indicated three (3) out of six (6) residents listed had diagnoses of schizophrenia, paranoid schizophrenia, or bipolar disorder. Throughout the survey between August 17, 2026, and August 19, 2026, the surveyor observed CNS-B interacting with multiple residents. CNS-B was hired on June 3, 2026, to supervise direct care staff working 15 to 20 hours per week for the licensee. CNS-B's employee file did not include any mental	01530			

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01530	Continued From page 27 illness and de-escalation training. On August 18, 2026, at 11:45 a.m., the surveyor asked CNS-B if she completed any mental illness and de-escalation training, she stated "no." The surveyor asked if there were mental illness training material available, CNS-B searched the computer and stated she could only find dementia training. On August 18, 2026, at 12:30 p.m., CNS-B stated they stopped providing mental illness training because their dementia training included mental illness topics. The surveyor requested to view the dementia training material to confirm mental illness was covered. On August 18, 2026, at 12:43 p.m., via email, the licensee provided the following dementia care modules: -Module 1-An Explanation of Alzheimer's & Other Dementia's; -Module 2-Assistance with ADL's (activities of daily living); -Module 3-Problem Solving Challenging Behaviors; -Module 4-Communication Skills; and -Module 5-Person Centered Planning & Service Delivery. The modules lacked topics related to mental illness and de-escalation. During exit conference on August 19, 2026, at 2:20 p.m., LALD/RN-A stated another ULP had online mental illness training, but it was not the case for everyone else. She also stated she would be reaching out to their consultant to get training material to meet the requirement. LALD/RN-A stated they did not have a policy available either.	01530			

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01530	Continued From page 28 The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated June 2021, indicated all staff of licensee providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services;	01620			

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01620	Continued From page 29 (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, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment to include all required content on the uniform assessment tool while completing admission and 14-day assessments for one of one resident (R3). 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	01620			

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01620	Continued From page 30 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: During the entrance conference on August 17, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated the RN completed full comprehensive nursing assessment upon admission, then within 14 days, and every 90 days. During facility tour with CNS-B on August 17, 2026, at 11:58 a.m., the surveyor asked CNS-B if there were refrigerated medications, and CNS-B stated there was insulin in the kitchen refrigerator. The surveyor opened the kitchen refrigerator and observed an unsecured box of Novolog insulin pens (fast-acting) that belonged to R3 on the shelf of the door. R3 was admitted for services on July 30, 2026, and had diagnoses including diabetes, schizophrenia, and major depressive disorder. R3's Master Care Plan last updated August 17, 2026, indicated R3 received assistance with medication administration/management, reminders, and behavior redirection. R3's 14-day nursing assessment dated August 17, 2026, indicated R3 was a diabetic and had been since they were 16 years old. The assessment lacked listing any treatments R3 had, including type, frequency, and level of assistance needed.	01620			

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01620	Continued From page 31 On August 19, 2026, at 9:31 a.m., CNS-B stated R3 self-administered their own insulin and monitored their own blood glucose, but she was not aware that should have been documented in the comprehensive assessment even if R3 self-managed them. The licensee's 6.01 Assessments, Reviews & Monitoring policy, undated, indicated the RN would complete the initial nursing assessment or reassessment that would include all the elements of the uniform assessment tool as required. Minnesota Administrative Rule 4659.0150, subpart 1 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	01700			

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01700	Continued From page 32 resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of two residents (R3) who received medication management services. 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: During the entrance conference on August 17, 2026, at 10:45 a.m., clinical nurse supervisor	01700			

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01700	Continued From page 33 (CNS)-B stated the licensee provided medication management services to their residents at the facility. During facility tour with CNS-B on August 17, 2026, at 11:58 a.m., the surveyor asked CNS-B if there were refrigerated medications, and CNS-B stated there was insulin in the kitchen refrigerator. The surveyor opened the kitchen refrigerator and observed an unsecured box of Novolog insulin pens (fast-acting) that belonged to R3 on the shelf of the door. The refrigerator was next to the walkway for the main entrance and the garage door where residents went through to smoke. The surveyor observed multiple staff and residents walking near the refrigerator. R3 was admitted for services on July 30, 2026, and had diagnoses including diabetes, schizophrenia, and major depressive disorder. R3's Master Care Plan last updated August 17, 2026, indicated R3 received assistance with medication administration/management, reminders, and behavior redirection. R3's 14-day nursing assessment dated August 17, 2026, indicated CNS-B assessed that R3 did not independently manage medication administration, staff provided full assistance with medication administration, including monitoring medication supply and coordinating refills and reorders as needed. The assessment also indicated all R3's medications were stored in a locked, secure medication storage area. Access was limited to authorized staff responsible for medication administration. The medication assessment did not indicate R3 would self-administer the Novolog insulin and lacked instructions on how R3's Novolog insulin pen	01700			

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01700	Continued From page 34 would be stored and who was responsible for reordering when needed. On August 19, 2026, at 9:31 a.m., CNS-B stated during the face-to-face medication assessment she observed R3 self-administer the Novolog insulin but was not aware that R3's record should include identification who was responsible for the administration, storing, and supply of the Novolog insulin. The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment, undated, indicated licensee would prior to providing medication management services, have a registered nurse (RN), licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services would be provided and how the services would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically	01820			

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01820	Continued From page 35 recorded prescriptions were obtained for one of one resident (R3). 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: R3 was admitted for services on July 30, 2026, and had diagnoses including diabetes, schizophrenia, and major depressive disorder. R3's Master Care Plan last updated August 17, 2026, indicated R3 received assistance with medication administration/management, reminders, and behavior redirection. R3's Verbal Order/Medication Confirmation Sheet signed by clinical nurse supervisor (CNS)-B on July 31, 2026, indicated R3's current medications included aripiprazole (anti-psychotic), atorvastatin (treats high cholesterol), bupropion (treats depression), cefdinir (antibiotic), glipizide (controls blood sugar levels), Jardiance (controls blood sugar levels), lisinopril (treats high blood pressure), mirtazapine (treats depression), omeprazole (treats excess stomach acid), amoxicillin/clavulanate (antibiotic), ciprofloxacin (antibiotic), fluoxetine (treats depression), gabapentin (treats nerve pain), and naltrexone (treats alcohol and opioid use disorder). R3's Med Admin Summary (medication	01820			

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01820	Continued From page 36 administration record (MAR)) for August 2026, indicated R3 took the following medications: -aripiprazole 10 milligram (mg), one tablet by mouth daily; -atorvastatin 40 mg, one tablet by mouth daily (started August 17, 2026); -bupropion hydrochloride 300 mg, one tablet by mouth daily; -cefdinir 300 mg, one capsule by mouth twice daily (ended on August 9, 2026); -ciprofloxacin 500 mg, one tablet by mouth twice daily for seven (7) days (started August 10, 2026); -doxycycline monohydrate 100 mg, one capsule by mouth twice daily for seven (7) days (started August 9, 2026 for infection); -fluoxetine 40 mg, one capsule by mouth daily; -gabapentin 800 mg, one tablet by mouth twice daily; -glipizide extended release (ER) 5 mg, one tablet by mouth daily before a meal (started August 17, 2026); -Jardiance 10 mg one table by mouth daily (started August 17, 2026); -lisinopril 40 mg, one tablet by mouth daily; -metronidazole 500 mg, one tablet three times a day (antibiotic); -naltrexone 50 mg, one tablet by mouth daily (ended August 9, 2026); -omeprazole 20 mg, one capsule by mouth twice daily before meals; and -mirtazapine 7.5 mg, one tablet by mouth every night. On August 18, 2026, at 1:15 p.m., CNS-B stated she received verbal orders from the provider but did not follow up to obtain signed orders. CNS-B then stated R3 had a medical appointment around August 5, 2026, and at that time the medications changed. The licensee faxed a request for signed orders on August 13, 2026, but	01820			

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01820	Continued From page 37 had not received it. CNS-B stated she was told by licensed assisted living director/registered nurse (LALD/RN)-A that they always required signatures, but CNS-B was not aware that electronic orders from the pharmacy could be accepted. On August 19, 2026, at 9:31 a.m., CNS-B stated when R3's orders had changed earlier August, she was in contact with the pharmacy technician to determine when medications needed to be discontinued, started, or changed. CNS-B stated she received the orders from the pharmacy the day before (during survey). On August 19, 2026, at 9:35 a.m., CNS-B provided prescriptions faxed to licensee on August 18, 2026, (during survey) by R3's pharmacy for amoxicillin and clavulanate, omeprazole, bupropion, mirtazapine, lisinopril, aripiprazole, Jardiance, doxycycline monohydrate, glipizide, gabapentin, fluoxetine, and atorvastatin. The licensee's 7.20 Medication & Treatment Orders, undated, indicated: -Current, authorized prescriber orders for medications administered by the staff are kept on file in the resident's records; and -An order for medication must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment; and -Upon receiving verbal orders or unsigned electronic orders, a licensed nurse would record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse would continue to follow-up with the prescriber's office until the signature was received.	01820			

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01820	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access for one of one resident (R3). 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: R3 was admitted for services on July 30, 2026, and had diagnoses including diabetes, schizophrenia, and major depressive disorder. R3's Master Care Plan last updated August 17,	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER ASPEN HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444		
(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
01880	Continued From page 39 2026, indicated R3 received assistance with medication administration and management, reminders, and behavior redirection. R3's Individual Medication Management Plan dated August 17, 2026, indicated all R3's medications were stored in a locked, secure medication storage area. Access was limited to authorized staff responsible for medication administration. During facility tour with clinical nurse supervisor (CNS)-B on August 17, 2026, at 11:58 a.m., the surveyor asked CNS-B if there were refrigerated medications, and CNS-B stated there was insulin in the kitchen refrigerator. The surveyor opened the kitchen refrigerator and observed an unsecured box of Novolog insulin pens that belonged to R3 on the shelf of the door. The refrigerator was next to the walkway for the main entrance and the garage door where residents went through to smoke. The surveyor observed multiple staff and residents walking near the refrigerator. CNS-B explained R3 self-administered his Novolog it was stored in the refrigerator. She was not aware that the insulin needed to be secured even if he self-administered. CNS-B stated they could get a miniature refrigerator for R3's room or figure out another option. The Licensee's 7.11 Medication Storage policy, undated, indicated medications would be stored consistent with each residents' medication management plan and service plan. Medications managed outside of a resident's private living space must be in securely locked and substantially constructed compartment and permit only authorized personnel to have access.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER ASPEN HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444			
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01880	Continued From page 40 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

ASPEN HOME HEALTH CARE INC
9508 UPTON AVENUE NORTH
Brook Park, MN
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35930

Risk:
License:
Expires on:
CFPM: Husan Robleh
CFPM #: 93538; Exp: 8/9/2027

Inspection Info

Report Number: F1025261168
Inspection Type: Full - Single
Date: 8/17/2026 Time: 11:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Dishwasher not working during inspection, reported waiting on missing part. Facility had a container, bleach, and a quat test kit. Provide a chlorine test kit because bleach is used for sanitizing. Reported using disposable plates and cutlery, as well. CFPM covers two locations. Discussed defrosting and cleaning the garage freezer, recommend putting a different counter or table out in the garage to keep residents from putting things on the freezer top.

Food TMD and dish machine test strips available. Discussed food cooking temperatures, sanitizing, cold holding temperatures, MN 4626.0506 cook/serve and equipment requirements, date marking, employee health and hygiene, food source and recalls.

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

I acknowledge receipt of the Metro District Office inspection report number F1025261168 from 8/17/2026

Establishment Representative


Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
ASPEN HOME HEALTH CARE INC	Report Number: F1025261168
Brook Park	Inspection Type: Full
County/Group: Hennepin County	Date: 8/17/2026
	Time: 11:30 AM

Equipment Temperature: Product/Item/Unit: Ambient; **Temperature Process:** Cold holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL35930016-0	Date: August 18, 2026
Facility Name: ASPEN HOME HEALTH CARE INC	
Facility Address: 9508 uptown ave north Minneapolis, Mn	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: The facility failed to ensure that lighted cigarettes and other smoking materials were discarded in a manner that prevented the ignition of combustible materials. Upon arrival at the facility, the surveyor observed discarded cigarette butts on the front side of the building adjacent to the garage, within the garage, and on a couch located inside the garage. In Resident Room 4, the surveyor observed cigarette butts discarded on the floor and in the window well. The surveyor also observed tobacco ash and burn marks on and around furnishings and detected a strong odor of cigarette smoke in the room. Directly outside the window of Resident Room 4, the surveyor observed discarded cigarette butts in the grass. The surveyor also observed burn marks on the rear exterior siding of the facility.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: Fire extinguishers were missing their annual service tags along with the required monthly maintenance inspection checks in accordance with Minnesota State Fire Code 906.

☒ **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 are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to maintain the FSEP as readily available on site. The surveyor requested FSEP for review at 1:55. HM/ULP-C provided a binder that did not contain an FSEP. The nurse evaluator received an email on August 18 at 10:30 a.m. from the provider. In the email, the provider indicated that the attachments were the FSEP for the facility.

2. 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 facility failed to maintain an accurate building floor plan and properly identify resident rooms. During the survey, the posted facility map depicted the layout of a different building rather than the surveyed facility. In addition, resident room doors were not labeled with room numbers or other identifiers.

3. 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. Policy noted use of sprinklers and smoke compartments with magnetic door releases which facility was not equipped with.

4. 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.