



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 1, 2026

Licensee

Vikings Home Health Care LLC
11551 Georgia Avenue North
Champlin, MN 55316

RE: Project Number(s) SL34710016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 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.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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

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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/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2026
NAME OF PROVIDER OR SUPPLIER VIKINGS HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316		
(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: SL34710016-0 On April 6, 2026, through April 10, 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 three residents; three receiving 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.		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 460			

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0 460	Continued From page 2 On April 6, 2026, at 11:18 a.m., during the facility tour, the surveyor did not observe a call system for residents. On April 4, 2026, at 11:36 a.m., unlicensed personnel (ULP)-A stated the licensee did not have a means for residents to summon assistance; and residents would need to yell for staff if they needed assistance. ULP-A stated only one of the three residents had access to a cell phone. On April 4, 2026, at 1:10 p.m., clinical nurse supervisor (CNS)-D stated the licensee did not have a call system in place or other means for residents to summon assistance. CNS-D stated the licensee had staff working 24 hours per day and it was a small facility. On April 10, 2026, at 3:09 p.m., owner (O)-F stated the licensee did have a call system in place for residents, but the call system was off the day the surveyor came. O-F stated a lot of the time the residents refuse to wear their pendent. The licensee's Scope of Service policy dated August 1, 2021, indicated residents would be provided with a system for accessing staff when needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550			

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0 550	Continued From page 3 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 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 the required information related to the grievance procedure. 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: On April 6, 2026, at 11:18 a.m., during the facility tour, the surveyor observed the licensee's posted grievance procedure. House manager (HM)-E	0 550			

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0 550	Continued From page 4 stated the person listed on the grievance post was no longer an active employee for the licensee. HM-E stated they had updated the contact information on the licensee's grievance post but never posted it. The licensee's Grievance policy dated August 1, 2021, indicated a copy of the grievance procedure would be conspicuously posted in the facility with the name, phone number and email contact information for the individuals who were responsible for handling resident complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to	0 630			

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0 630	Continued From page 5 include the required content for two of two 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 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: R1 On April 8, 2026, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026, indicated R1 received assistance with medication administration. R1's IAPP dated April 7, 2026, lacked an assessment of the resident's risk of abusing other vulnerable adults. R2 On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. R2 was admitted to the licensee on September 23, 2020, due to diagnosis of autism spectrum disorder.	0 630			

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0 630	Continued From page 6 R2's Service Plan dated March 25, 2026, indicated R2 received assistance with medication administration. R2's IAPP dated April 8, 2026, lacked an assessment of the resident's susceptibility to abuse by another individual. Also, R2's IAPP indicated R2 had a history of threatening self-injurious behavior if they did not get their way but lacked specific interventions to reduce the risk. On April 10, 2026, at 4:10 p.m., clinical nurse supervisor (CNS)-D stated they were aware of the statute requirements, but it was an oversight; and they would update the IAPPs. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated an IAPP would be established for each vulnerable adult for whom assisted living services were provided; and the plan would contain an assessment of the resident's susceptibility to abuse by another individual and the risk of abusing other vulnerable adults. The policy indicated the IAPP would contain statements of specific measures to be taken to minimize the risk of abuse for that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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	0 650			

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0 650	Continued From page 7 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 observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two unlicensed personnel ((ULP)-A, ULP-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:	0 650			

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0 650	Continued From page 8 ULP-A ULP-A was hired on November 20, 2023. On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's personnel record lacked documentation of the following training and competency evaluation as follows: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications on all routes; - giving medications to residents for unplanned times away; and - blood glucose. On April 8, 2026, at 8:14 a.m., ULP-A stated the previous nurse who had worked for the licensee had trained and observe them perform medication administration, giving medications to residents with an unplanned time away, checking vital signs, bathing, blood glucose, transfers, and range of motion. ULP-B ULP-B was hired on December 24, 2021. ULP-B's personnel record lacked evidence of completed annual performance reviews for 2022, 2023, and 2024.	0 650			

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0 650	Continued From page 9 ULP-B's personnel record lacked documentation of the following training and competency evaluation as follows: - care of teeth, gums, and oral prosthetic devices; and - standby assistance techniques and how to perform them. On April 7, 2026, at 10:09 a.m., house manager (HM)-E confirmed ULP-B's personnel record did not have any performance reviews prior to 2025. On April 9, 2026, at 2:04 p.m., ULP-B stated the previous nurse who had worked for the licensee had trained and observe them perform oral care and standby assist techniques. On April 8, 2026, at 12:28 p.m., clinical nurse supervisor (CNS)-D stated they provided training and competency evaluations for both ULP-A and ULP-B on medications, activities of daily living (ADLs), and transfers. CNS-D stated they had signed off for ULP-A and ULP-B as being competent; and did not know why this documentation was not in their personnel records. CNS-D stated they completed a competency evaluation with ULP-A for blood glucose and had determined they were competent to provide this treatment. CNS-D stated ULP-A was trained in how to provide medications to residents when they had an unplanned time away; and the training also included how to document and pull a form required from the licensee's electronic medical record. On April 10, 2026, at 3:23 p.m., HM-E stated the licensee was aware of the required contents for personnel records.	0 650			

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0 650	Continued From page 10 On April 10, 2026, at 3:25 p.m., CNS-D stated it was an oversight for not having ULP-B's annual performance reviews prior to 2025 and the training and competency evaluations in the personnel records. The licensee's Personnel Records dated August 1, 2021, indicated all documents related to annual performance reviews and competency evaluations would be kept in the personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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. This MN Requirement is not met as evidenced	0 660			

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0 660	Continued From page 11 by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) infection control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included facility TB risk assessment, TB training, and TB screening for two of two unlicensed personnel ((ULP)-A, ULP-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: The licensee's Facility TB Risk Assessment dated October 15, 2025, identified a different facility name and address for the facility TB risk assessment. Also, the TB risk assessment did not indicate the current incidence of TB for the National or State rate from 2024; and did not indicate County data from 2024. The facility TB risk assessment indicated the risk level was zero, which was not accurate per the incidence of TB rates. ULP-A ULP-A was hired on November 20, 2023. On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration.	0 660			

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NAME OF PROVIDER OR SUPPLIER VIKINGS HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316			
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0 660	Continued From page 12 ULP-A's QuantiFERON TB Gold Plus (serum blood test) dated November 16, 2023, indicated ULP-A had positive TB test results. ULP-A's XR Chest 2 Views (chest x-ray) dated November 22, 2023, indicated no evidence for active TB. ULP-A's record lacked documentation of treatment for latent TB and lacked documentation of annual TB symptom screen (as the licensee's policy indicated annual TB symptom screen would be completed for untreated latent TB). ULP-A's personnel record lacked annual TB training in 2024 and 2025. On April 8, 2026, at 8:14 a.m., ULP-A stated they completed TB training upon hire but did not recall any other training on TB. ULP-B ULP-B was hired on December 24, 2021. ULP-B's tuberculin skin testing (TST) results read on November 18, 2019, indicated a positive reaction. ULP-B's Positive Mantoux Assessment from a medical provider dated November 18, 2019, indicated ULP-B had a negative chest x-ray result. ULP-B's record lacked documentation of treatment for latent TB and lacked documentation of annual TB symptom screening (as the licensee's policy indicated annual TB symptom screen would be completed for untreated latent TB).	0 660			

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0 660	Continued From page 13 ULP-B's personnel record lacked annual TB training in 2022, 2023, 2024 and 2025. On April 8, 2026, at 11:48 a.m., licensed assisted living director (LALD)-G stated the licensee does get the incidence of TB data from the MDH website annually; however, the most recent TB risk assessment was completed in error. LALD-G stated the licensee had stopped the annual TB screening as they thought it was no longer necessary. LALD-G stated the licensee completed TB training at hire. LALD-G stated the license used to provide TB training annually, but that had stopped when the licensee no longer completed annual TB symptom screening. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the director was responsible for conducting the formal TB risk assessment annually; ongoing education regarding TB would be provided annually to all staff who provided care; and annual symptom screening would be completed for health care personnel with untreated latent TB. 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 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680			

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0 680	Continued From page 14 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z; failed to post the EPP prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680			

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0 680	Continued From page 15 The findings include: On April 6, 2026, at 11:18 a.m., during a facility tour, the surveyor did not observe the EPP posted prominently. The licensee's undated EPP lacked evidence of the following required content: - maintain and annual EP updates; - EP program patient population; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; and - methods for sharing information. On April 7, 2026, at 1:34 p.m., licensed assisted living director (LALD)-G stated they did not think the licensee reviewed the missing resident plan quarterly. LALD-G confirmed the licensee's delegation of authority identified staff that were no longer employed by the licensee as the back-up incident commander. LALD-G stated the licensee would normally have resident information included in the EPP to help identify at risk populations. LALD-G confirmed the licensee did not have a policy and procedure for tracking residents or staff during an emergency or disaster; and the EPP had other missing content that was required. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place an emergency preparedness plan. The policy referenced CMS (Centers for Medicare and Medicaid Services) Appendix Z and MN Rules 4659.0100.	0 680			

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0 680	Continued From page 16 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730			

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0 730	Continued From page 17 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident's record included a fully executed written contract for one of one resident (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 July 5, 2024. R1's Assisted Living Contract dated July 1, 2024, included pages that were signed but lacked the other pages of the contract with the required	0 730			

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0 730	Continued From page 18 content of an assisted living contract. On April 8, 2026, at 2:32 p.m., house manager (HM)-E stated the licensee did not have the whole fully executed contract for R1 as they could only locate the signature pages. HM-E stated they thought it may have been lost. On April 9, 2025, at 11:46 a.m., HM-E confirmed the licensee did not have any other contracts signed by R1 on file. The licensee's Clinical Records policy dated August 1, 2021, indicated all records would be protected against loss; and accessible to employees to access records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
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	0 775			

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0 775	Continued From page 19 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 April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) Days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780			

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0 780	Continued From page 20 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 780			

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0 810 SS=C	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810			

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0 810	Continued From page 22 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 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 the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 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	0 970			

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0 970	Continued From page 23 licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of two residents (R2). 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 the potential to affect a large portion or all the residents). The findings include: R2 was admitted to the licensee on September 23, 2020. R2's Assisted Living Contract dated August 1, 2021, under indemnification, indicated the licensee shall not be liable for any damage or injury to the residents; and the resident holds the licensee harmless from any claims or damages unless caused solely by negligence of the licensee. On April 9, 2026, at 3:34 p.m., house manager (HM)-E stated the licensee was not aware the assisted living contract could not have a waiver of liability. HM-E stated they would make sure to not have a waiver of liability in the contract going forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			

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01320	Continued From page 24	01320			
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for one of two unlicensed personnel ((ULP)-A). 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).	01320			

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01320	Continued From page 25 The findings include: ULP-A was hired on November 20, 2023. On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. On April 6, 2026, at 1:15 p.m., the surveyor verified ULP-A was not listed on the Minnesota Nurse Aide Registry as a current certified nursing assistant. ULP-A's personnel record lacked evidence of completed training and/or competency testing for the following required topics: - care and use of hearing aids; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; and - awareness of commonly used health technology equipment and assistive devices. On April 8, 2026, at 8:14 a.m., ULP-A stated they were not trained on hearing aids since the licensee did not have any residents with hearing aids. On April 8, 2026, at 12:28 p.m., clinical nurse supervisor (CNS)-D stated the use of hearing aid was part of the licensee's training, but they just talked about this topic with the ULPs since the licensee did not have any residents that used hearing aids. On April 8, 2026, at 12:30 p.m., licensed assisted living director (LALD)-G stated the licensee would only complete a competency evaluation if they had a resident with that need.	01320			

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01320	Continued From page 26 The licensee's Staff Competency policy dated August 1, 2021, indicated ULPs may not work for the licensee until they successfully passed the written (at 80 percent) and demonstration competency evaluation on topics that included the use of hearing aids, basic nutrition, meal preparation, preparation of modified diets, food safety, assistance with eating, and awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first	01440			

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01440	Continued From page 27 performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. 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) completed supervision of unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for one of two unlicensed personnel ((ULP)-A). 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: ULP-A was hired on November 20, 2023. On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's personnel record lacked evidence of an RN conducted direct supervision of staff who performed delegated tasks within 30 days of provided services. On April 6, 2026, at 2:44 p.m., licensed assisted living director (LALD)-G stated the licensee had the house manager perform 30-day supervisions.	01440			

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01440	Continued From page 28 LALD-G stated anyone from the administration staff could complete the 30-day supervision, which included the house manager or the LALD. On April 8, 2026, at 12:43 p.m., clinical nurse supervisor (CNS)-D stated they had completed 30-day supervisions for the licensee. CNS-D stated there was another nurse who had worked for the licensee previously so they could not confirm if a 30-day supervision was completed by an RN for ULP-A. On April 8, 2026, at 12:51 p.m., LALD-G confirmed LALD-C had completed ULP-A's 30-day supervision as it was a misunderstanding of the need to have an RN complete the 30-day supervisions for delegated tasks. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated direct supervision of staff who performed delegated tasks such as medication or treatment administration would be completed by an RN within 30 days after the individual began working for the assisted living provider; and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500			

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01500	Continued From page 29 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01500			

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01500	Continued From page 30 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for two of two unlicensed personnel ((ULP)-A, ULP-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: ULP-A ULP-A was hired on November 20, 2023. On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's employee record lacked evidence of the	01500			

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01500	Continued From page 31 following required topics of annual training in 2024: - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. ULP-A's employee record lacked evidence of the following required topics of annual training in 2025: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500			

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01500	Continued From page 32 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-B ULP-B was hired on December 24, 2021. ULP-B's employee record lacked evidence of the following required topics of annual training in 2024: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500			

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01500	Continued From page 33 residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-B's employee record lacked evidence of annual training in 2025 regarding the required topic on the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On April 7, 2026, at 9:07 a.m., house manager (HM)-E stated they recently started to oversee the licensee's annual education the licensee provided through Educare (common online education program) as of October 2025. HM-E stated they followed the guidelines required on the MDH website and used a printout from Educare that had all the required training topics for the licensee's new hires and annual training. On April 8, 2026, at 8:14 a.m., ULP-A stated all annual training provided by the license was completed through Educare. On April 8, 2026, at 12:20 p.m., licensed assisted living director (LALD)-G stated the licensee needed to provide four hours of annual training along with two hours of dementia training and one hour of mental illness training. LALD-G stated LALD-C was supposed to work on the required training. LALD-G stated the licensee used to have a different house manager that used to check the assigned courses weekly, but they did not think	01500			

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01500	Continued From page 34 the current house manager had been checking to see if the courses were being completed on time by the staff. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff who provided assisted living services would complete eight hours of education for every 12 months of employment; and the training indicated included all required topics per Statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
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 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	01530			

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01530	Continued From page 35 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 all employees received two (2) hours of annual dementia care training for direct care employees as required for two of two unlicensed personnel ((ULP)-A. ULP-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).	01530			

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01530	Continued From page 36 The findings include: ULP-A ULP-A was hired on November 20, 2023. On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A's personnel record lacked two (2) hours of annual dementia care training in 2024 and 2025. On April 8, 2025, at 8:14 a.m., ULP-A stated they could not recall when they had dementia training but had some dementia training. ULP-A stated they remembered doing some training when they were first hired. ULP-B ULP-B was hired on December 24, 2021. ULP-B's personnel record lacked two (2) hours of annual dementia care training in 2024. On April 7, 2026, at 9:07 a.m., house manager (HM)-E stated they recently started to oversee the licensee's annual education provided through Educare (common online education program) as of October 2025. HM-E stated they followed the guidelines required on the MDH website and utilized a printout from Educare that had all the required training topics for the licensee's new hires and annual training. On April 8, 2026, at 12:20 p.m., licensed assisted living director (LALD)-G stated the licensee needed to provide two hours of dementia training annually. LALD-G stated LALD-C was supposed to work on the required training. LALD-G stated the licensee used to have a different house	01530			

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01530	Continued From page 37 manager that used to check the assigned courses weekly, but they did not think the current house manager had been checking to see if the courses were being completed by the staff. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees would complete two hours of education on topics related to dementia for each twelve months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=D	144G.70 Subd. 2 (a-b) 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. This MN Requirement is not met as evidenced	01610			

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01610	Continued From page 38 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for one of two residents (R1) receiving 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: On April 8, 2026, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026, indicated R1 received assistance with medication administration. R1's Assessment History by Client dated April 8, 2026, indicated R1 had a pre-admission assessment completed on July 26, 2024; and an admission assessment completed on July 30, 2024. R1's record lacked an initial assessment that was completed prior to the date on which a	01610			

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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
01610	Continued From page 39 prospective resident executed a contract with the facility or on the day the resident moved in. On April 10, 2026, at 3:42 p.m., clinical nurse supervisor (CNS)-D confirmed R1 did not have an initial assessment completed until July 30, 2024. CNS-D stated R1 moved into the facility on July 5, 2024, but the next day, R1 went to hospital for about three weeks. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the initial RN assessment would be completed prior to the date on which the prospective resident executed a contract or on the date on which the prospective resident moved in, which ever was earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01620 SS=F	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	01620			

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01620	Continued From page 40 circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living 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	01620			

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01620	Continued From page 41 registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment; and failed to ensure an RN completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for two of two 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 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: R1 On April 8, 2026, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026, indicated R1 received assistance with medication administration. R1's record included 90-day nursing assessments completed on December 3, 2025, and March 10, 2026. The 90-day assessment completed on March 10, 2026, indicated 97 days had passed since the previous 90-day assessment completed December 3, 2025. The	01620			

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01620	Continued From page 42 assessments failed to ensure the RN conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment. R1's 90-day assessments completed on December 3, 2025, and March 10, 2026, failed to address the required content per Minnesota Administrative Rule 4659.0150 as indicated below: - personal lifestyle preferences: sleep schedule, leisure activities, cultural preferences; - physical health status: a review of medical and dental visits in the past 12 months, vital signs, weight; - emotional and mental health conditions: current symptoms of mental health conditions, behavioral expressions of concerns, effective medication treatment and non-medication interventions; - cognition: current memory or confusion; - communication: the ability to understand; - hydration status and preferences; - list of treatments to include type, frequency, and level of assistance needed; - risk indicators: risk for falls, including history of falls, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, unsuccessful prior placements, alcohol and drug use; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. R2 On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. R2 was admitted to the licensee on September 23, 2020, due to diagnosis of autism spectrum disorder.	01620			

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01620	Continued From page 43 R2's Service Plan dated March 25, 2026, indicated R2 received assistance with medication administration. R2's record included 90-day nursing assessments completed on December 3, 2025, and March 10, 2026. The 90-day assessment completed on March 10, 2026, indicated 97 days had passed since the previous 90-day assessment completed December 3, 2025. The assessments failed to ensure the RN conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment. R2's 90-day assessment completed on March 10, 2026, failed to address the required content per Minnesota Administrative Rule 4659.0150 as indicated below: - emotional and mental health conditions: current symptoms of mental health conditions, behavioral expressions of concerns, effective medication treatment and non-medication interventions; - cognition: current memory, confusion, and decision-making status and ability; - communication: hearing, the ability to understand; and - risk indicators: unsuccessful prior placements, smoking, alcohol and drug use. On April 10, 2026, at 3:42 p.m., clinical nurse supervisor (CNS)-D stated the licensee's electronic medical record system gave CNS-D a reminder for an assessment due, however, if the resident goes out for the day, then they could not complete the assessment. CNS-D stated they would set up the assessment reminder for every 90 days. CNS-D was not aware of the uniform Assessment tool and the required content for an	01620			

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01620	Continued From page 44 assessment. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and could not exceed 90 days from the last date of assessment. Minnesota Administrative Rule 4659.0140, subpart 2, B., (3) dated August 11, 2021, indicated the nursing assessment or reassessment must be conducted using a uniform assessment tool that complied with part 4659.0150. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (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.	01640			

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01640	Continued From page 45 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current service plan was completed within fourteen days of starting services; and failed to ensure the current service plan included a signature or other authentication by the licensee and by the resident or resident's representative to document agreement of services to be provided for two of two 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 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: R1 On April 8, 2026, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026,	01640			

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01640	Continued From page 46 indicated R1 received assistance with medication administration. R1's Service Plan was signed by R1 or R1's representative on March 24, 2026, but lacked a signature from a representative of the licensee. R1's record lacked a service plan prior to March 24, 2026. R2 On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. R2 was admitted to the licensee on September 23, 2020, due to diagnosis of autism spectrum disorder. R2's Service Plan dated March 25, 2026, indicated R2 received assistance with medication administration. R2's Service Plan lacked a signature from a representative of the licensee and the resident or resident's representative with all current services provided by licensee. R2's record lacked a service plan prior to March 25, 2026. On April 9, 2026, at 12:46 p.m., house manager (HM)-E acknowledged the service plans did not have signatures. HM-E confirmed they could not find any other service plans for R1 and R2 in the resident records. The licensee's Service Plan policy dated August 1, 2021, indicated an individualized service plan would be implemented for all residents; and the service plan would be finalized no later than 14 days after the date services were first provided. Also, the policy indicated the service plan would	01640			

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01640	Continued From page 47 be signed by a representative from the licensee and the resident or resident's representative to indicate an agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are	01690			

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01690	Continued From page 48 being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines for controlled substances that ensure security and accountability for the overall management and control of those substances in compliance with state and federal regulations. This had the potential to affect all residents and staff. 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 Storage/Control of Medications policy dated August 1, 2021, indicated schedule II-controlled substances would be stored in a separately locked compartment. Also, the policy indicated the registered nurse was responsible for establishing a protocol related to monitoring and	01690			

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01690	Continued From page 49 securing controlled medications based on the initial assessment and risk of diversion. On April 6, 20206, at 10:34 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D stated the licensee had one resident with a controlled substance medication (R1). CNS-D stated the controlled medications were stored in a small room that was locked. Staff documented the counts in a narcotic book; and the nurse checked the counts weekly and documented those counts in the licensee's electronic record. On April 8. 2026, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-A administer a controlled medication to R1. The controlled medication was preset up inside of a prefilled pharmacy pack for each day/time the medication was to be administered. The surveyor observed five separate prefilled packs for the following days/times: April 8, 2026, morning; April 8, 2026, evening; April 9, 2026, morning; April 9, 2026, evening; April 10, 2026, morning; and April 10, 2026, evening. The surveyor observed that each prefilled package from the pharmacy was opened and resealed with tape; and had clonazepam 0.5 milligram (mg) handwritten on each prefilled package. The controlled medication was not stored separately from other medications. ULP-A was not observed to perform a count of the controlled medication and did not document any counts when they administered R1's medication that was a controlled substance. R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026, indicated R1 received assistance with medication	01690			

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01690	Continued From page 50 administration. R1's record lacked an assessment of R1's medication that was a controlled substance for monitoring, securing, and the risk of diversion of the controlled medication. On April 8, 2026, at 1:02 p.m., CNS-D stated they normally did a medication count every week and documented the count in the licensee's narcotic book and electronic record after they set up R1's medication that was a controlled substance. On April 10, 2026, at 4:04 p.m., CNS-D stated they did not have a protocol related to monitoring and securing controlled substances, but they did control R1's medication that was a controlled substance when they set up the medication weekly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690			
01700 SS=F	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 51 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 two of two 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 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: R1 On April 8, 2026, at 9:40 a.m., the surveyor	01700			

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01700	Continued From page 52 observed unlicensed personnel (ULP)-A assist R1 with medication administration. R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026, indicated R1 received assistance with medication administration. R1's record lacked a completed medication assessment by a registered nurse that included required content as follows: - the reason taken; - any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - any difficulties the resident faces in taking the medication; - the resident's preferences in how to take medication; - 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 resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. R2 On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. R2 was admitted to the licensee on September 23, 2020, due to diagnosis of autism spectrum disorder.	01700			

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01700	Continued From page 53 R2's Service Plan dated March 25, 2026, indicated R2 received assistance with medication administration. R2's record lacked a completed medication assessment by a registered nurse that included required content as follows: - the reason taken; - any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - any difficulties the resident faces in taking the medication; - the resident's preferences in how to take medication; - 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 resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On April 10, 2026, at 3:42 p.m., clinical nurse supervisor (CNS)-D stated they were not aware of the uniform assessment tool and the required content for an assessment. The licensee's Assessment of Medications policy dated August 1, 2021, indicated the licensee would, prior to providing medication management services, have an RN conduct an assessment to determine what medication management services would be provided and how the services would be provided. The policy indicated a medication reassessment would occur with resident symptomology; problems or concerns that may be medication-related; with new prescriptions,	01700			

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NAME OF PROVIDER OR SUPPLIER VIKINGS HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316		
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01700	Continued From page 54 OTC or herbal products; and annually. The policy indicated all of the required content per Minnesota Administrative Rule 4659.0150, subpart 2, D, 4. Minnesota Administrative Rule 4659.0150, subpart 2, D, 4 dated August 11, 2021, indicated the required elements of the uniform assessment tool included a review of medications that included prescriptions, over-the-counter medication, and supplements, and for each: - the reason taken; - any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - the dosage; - the frequency of use; - the route administered or taken; - any difficulties the resident faces in taking the medication; - whether the resident self administers the medication; - the resident's preferences in how to take medication; - 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 resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			

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01730	Continued From page 55	01730			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be	01730			

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01730	Continued From page 56 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for two of two 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 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: R1 On April 8, 2026, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. During the surveyor's observation of the medication administration, R1 asked ULP-A to chop the medications up like they always did. ULP-A placed two tablets on a spoon full of yogurt. R1 stated again, "why are you not chopping it like you always do?" ULP-A proceeded to give two tablets on the spoon with yogurt. It was not clear to the surveyor how R1 was to have their medications	01730			

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01730	Continued From page 57 administered (whole, cut up, crushed, or put in food). R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026, indicated R1 received assistance with medication administration. R1's Individualized Medication Management Plan (IMMP) dated March 10, 2026, indicated under the section, method for unlicensed staff to contact the nurse if questions or concerns arise, specify: side effects. R1's IMMP did not include procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and did not indicate what side effects to notify a nurse. R1's record lacked the following required content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - procedures for staff notifying a registered nurse or appropriately licensed health professional when a problem arises with medication management services. R2 On April 8, 2026, at 8:00 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A had gathered R2's medication from a locked medication cabinet in the common dining room area. R2 was admitted to the licensee on September 23, 2020, due to diagnosis of autism spectrum	01730			

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01730	Continued From page 58 disorder. R2's Service Plan dated March 25, 2026, indicated R2 received assistance with medication administration. R2's IMMP dated March 10, 2026, indicated R2 was to have all medication locked in a secured room, however the surveyor had observed the medications to be stored in a common area in a locked medication cabinet. The description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistency with the manufacturer's directions was not current. R2's record lacked the following required content: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; and - identification of medication management tasks that may be delegated to unlicensed personnel. On April 10, 2026, at 4:19 p.m., clinical nurse supervisor (CNS)-D stated they were aware of the required content, but this was an oversight. The licensee's undated Medication Management Program policy indicated admission to the medication management program would be at the discretion of the registered nurse (RN) and based on an assessment but failed to indicate a current individualized medication management record was required for each resident receiving medication management. The policy failed to identify the individualized medication management plan must be reviewed annually and as needed with changes. Also, the policy failed to identify the individualized medication	01730			

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01730	Continued From page 59 management record must contain the following: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750			

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01750	Continued From page 60 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have the registered nurse (RN) specified in writing, specific instructions for the delegation of medication administration 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 8, 2026, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. ULP-A gathered a prefilled pharmacy pack that indicated April 8, Wednesday morning. The following medications were listed on the pharmacy pack: one ferrous gluconate 324 milligram (mg) tablet; one fiber-lax 625 mg tablet; four metformin 500 mg extended release (er) tablets; one vitamin D3 25 micromilligrams (mcg) tablet; and a handwritten note added for clonazepam 0.5 mg. The surveyor observed ten tablets inside of the prefilled pharmacy pack, however the package indicated	01750			

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01750	Continued From page 61 there should have been a total of eight tablets. ULP-A dumped all the medications from the prefilled pharmacy pack into a larger plastic container. ULP-A did not compare the actual medications to be administered to R1's MAR. ULP-A proceeded to give two tablets on the spoon with yogurt. The surveyor asked ULP-A to step aside before giving more medications to R1. In another room, the surveyor asked ULP-A if they could verify the medication count prior to medication administration. ULP-A stated, "it was nine, [R1] always has nine pills". The surveyor showed ULP-A a picture of the medications that were placed in the plastic container just prior to R1's medication administration and asked if they could reverify the number of pills in the picture that were in the container. ULP-A stated ten tablets, sometimes R1 had nine tablets as one of them was not every day. The surveyor asked ULP-A how they would identify the medications they were about to administer. ULP-A stated they would give the medications indicated on the prefill pack, then check off as given in the computer; and tell R1 what medications they gave. The surveyor asked ULP-A if they saw any issues with the medications that were about to be administered to R1. ULP-A stated, "yes, there are more medications in the container, I cannot tell cause the medications are all mixed up." The surveyor asked ULP-A if there was a way to identify each tablet to be administered. ULP-A stated, "it doesn't say". The survey confirmed with ULP-A they could not identify the tablets about to be administered to R1 other than what was written on the package. On April 8, 2026, at approximately 9:50 a.m., after the surveyor observed ULP-A initiate medication administration for R1, ULP-A called clinical nurse supervisor (CNS)-D on speaker via cell phone.	01750			

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01750	Continued From page 62 ULP-A stated, "how do you know what medications are in the container? I cannot describe what each medication is." CNS-D stated, you are not supposed to know, it is packaged by the pharmacy. It is your job to give the medications to the residents. CNS-D then asked if it was the right date, time, and patient? CNS-D stated to ULP-A, "your job is not to describe the medications; I package the medications for you; if you are confused then you call me." The surveyor then stepped in and informed CNS-D of the concerns with the medication count indicated on the package compared to the actual number of tablets inside of the package. CNS-D asked ULP-A to facetime via phone. ULP-A reviewed all medications with CNS-D. CNS-D stated the pharmacy put R1's ferrous sulfate in the morning but R1's MAR indicated this was to be administered in the evening and not in the morning. Also, CNS-D stated the pharmacy put two tablets of R1's vitamin D3 but this should be one tablet. CNS-D told ULP-A to remove two pills (one vitamin D3 and one ferrous gluconate). The surveyor observed R1's medications set up to be administered were still not correct; and asked CNS-D to look at R1's metformin dose. CNS-D reconfirmed all medications that were set up for administration utilizing a picture the surveyor took. CNS-D stated R1 should have only four tablets of metformin set up but noted there were five tablets set up to be administered. CNS-D instructed ULP-A to also remove one metformin tablet from the medications set up to be administered. CNS-D stated they would come to the facility to check the other medications set up for R1 for the week; and instructed ULP-A to place the medications they removed into a plastic zip lock bag for the nurse.	01750			

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01750	Continued From page 63 R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026, indicated R1 received assistance with medication administration. R1's Med Admin Summary - Month dated April 2026, indicated R1 was to receive the following medications on April 8, 2026, in the morning (AM): - clonazepam 0.5 mg take one tablet by mouth twice daily; - fiber-lax 6.25 mg take one tablet by mouth once daily; - metformin 500 mg ER take four tablets (2,000) by mouth twice daily; and - vitamin D3 25 mcg take one tablet by mouth once daily. R1's Med Admin Summary - Month dated April 2026, indicated R1 was to receive the following medications on April 8, 2026, in the evening (PM) for ferrous gluconate 324 mg one tablet by mouth every Monday, Wednesday, and Friday for iron deficiency. R1's Med Setup/Review Summary - Month dated April 1, 2026, through April 30, 2026, indicated CNS-D set up the following medications on March 28, 2026, for medications to be administered on April 8, 2026: - clonazepam 0.5 mg take one tablet by mouth twice daily; - fiber-lax 6.25 mg take one tablet by mouth once daily; - metformin 500 mg ER take four tablets (2,000) by mouth twice daily; and - vitamin D3 25 mcg take one tablet by mouth once daily.	01750			

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01750	Continued From page 64 R1's record lacked specific instructions for the delegation of medication administration for R1 to include the process of medication administration of medications previously set up by the pharmacy or nurse. On April 10, 2026, at 4:10 p.m., stated the staff should be verifying the resident and the medications. CNS-D stated the staff can see the medication count. CNS-D stated if medication count was wrong on a medication set up then the staff should call the nurse, however, some staff were not counting the medications that had been set up by the pharmacy or nurse. CNS-D stated they needed to follow up with staff to make sure they were doing that correctly. The licensee's Delegation of Assisted Living Tasks policy dated August 1, 2021, indicated the clinician (RN) may delegate procedures according to the following: - RN instructed the ULP in proper methods to perform the procedure with respect to each resident; - RN provided the ULP with written instructions specific to the resident; - ULP demonstrated to the RN competence in the procedure; - the procedure is documented in the resident's clinical record; and - the ULP's competence is documented in his/her personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			

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01760	Continued From page 65	01760			
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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure accurate transcription for a prescription for one of one resident (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 July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026,	01760			

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01760	Continued From page 66 indicated R1 received assistance with medication administration. R1's order dated March 17, 2026, indicated R1 was to receive metformin 500 mg, four tablets by mouth daily. R1's Med Admin Summary - Month dated April 2026, indicated R1 was to receive metformin 500 mg, four tablets by mouth twice daily. On April 10, 2026, at 4:22 p.m., clinical nurse supervisor (CNS)-D stated there was an error for the transcription of R1's metformin. The licensee's Prescriber Orders dated August 1, 2021, indicated the registered nurse was responsible for implementing medication orders. The policy did not indicate any information on the transcription of a medication order. 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 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	01890			

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NAME OF PROVIDER OR SUPPLIER VIKINGS HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 67 review, the licensee failed to ensure expired medications were disposed of for three of three residents (R1, R2, 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: On April 7, 2026, at 8:34 a.m., the surveyor observed the licensee's medication storage cabinet that had the residents' current and active medications to be administered and observed the following discontinued or expired medications: -R1's melatonin 3 milligrams (mg) tablets expired on August 1, 2025; -R1's melatonin 3 mg tablets expired on September 16, 2025; -R2's quetiapine 25 mg tablets expired on August 27, 2025; -R3's cefuroxime 500 mg dispensed on December 27, 2024, was to be used for 14 days; -R3's nicotine transdermal system patch expired February 2026; -R3's antacid regular strength 200-200-20 mg suspension was to be discarded by January 2, 2025; -R3's prochlorper 10 mg expired on July 15, 2025; and -over-the-counter melatonin 1 mg expired January 2026. On April 7, 2026, at 9:25 a.m., clinical nurse	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2026
NAME OF PROVIDER OR SUPPLIER VIKINGS HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 68 supervisor (CNS)-D stated they checked the licensee's medication storage cabinet monthly for all medication expiration dates; and would destroy any expired medications. CNS-D stated the staff check the dates too and let the nurse know to see if they were able to give the medications. CNS-D stated all expired and discontinued medications would go in a separate locked closet on the lower level of the facility as they should be removed from the active medication storage. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated medications that were discontinued or expired would be disposed of by the licensed nurse according to instructions on the drug label; household trash mixed with undesirable substance; or a community drug take back program. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
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:	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2026
NAME OF PROVIDER OR SUPPLIER VIKINGS HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316		
(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
01970	Continued From page 69 Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronic treatment orders were maintained for one of one resident (R1) with a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On April 8, 2026, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. R1 was admitted to the licensee on July 5, 2024, with a diagnosis of schizophrenia. R1's Service Plan dated March 24, 2026, indicated R1 received assistance with blood glucose two times per week. R1's Service Recap Summary dated April 2026, indicated R1 received assistance with blood glucose two times per week on Thursdays and Saturdays in the mornings. R1's Provider Contact dated September 17, 2024, indicated R1's provider ordered to decrease blood glucose checks to twice per week. R1's record lacked up-to-date written or electronic	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2026
NAME OF PROVIDER OR SUPPLIER VIKINGS HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316			
(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
01970	Continued From page 70 orders authenticated by R1's provider. On April 10, 2026, at 9:54 a.m., house manager (HM)-E confirmed the licensee did not have any blood glucose orders for R1 after September 17, 2024. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated treatment orders would be renewed at least every year or when changes occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			



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

Vikings Home Health Care LLC
11551 GEORGIA AVENUE NORTH
Champlin, MN 55316
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34710

Risk:
License:
Expires on:
CFPM: BATHR-ULDHIN I. OMAR
CFPM #: FM117223; Exp: 06/12/2026

Inspection Info

Report Number: F8087261073
Inspection Type: Full - Single
Date: 4/7/2026 Time: 4:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: TEXTURED, ROUGH, APPEARS TO BE DURABLE - NON-COMPLIANT

FLOORS: TILE - COMPLIANT

COUNTERTOPS: LAMINATE - NON COMPLIANT

CABINETS: WOOD - NON COMPLIANT

REFRIGERATOR/FREEZER: FRIGIDARE

DISHWASHER: FRIGIDARE

STOVE/RANGE: WHIRLPOOL

MICROWAVE: SAMSUNG

HAND WASHING SINK: YES - RIGHT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

NON COMPLIANT COUNTERTOP, CEILING AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. PROBE THERMOMETER USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR Rhawnie Quinehan.

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 F8087261073 from 4/7/2026

John Boettcher

MARIAM ALI
HOUSE MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@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

Vikings Home Health Care LLC
Champlin
County/Group: Hennepin County

Inspection Info

Report Number: F8087261073
Inspection Type: Full
Date: 4/7/2026
Time: 4:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 33 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 33 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 33 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Freezer at 0 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL34710016-0	Date: 4/7/2026
Facility Name: VIKINGS HOME HEALTH CARE LLC	
Facility Address: 11551 GEORGIA AVENUE NORTH CHAMPLIN MN 55316	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) 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. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

Comments: The provided cigarette receptacle was a plastic coffee can.

3. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: The main level carbon monoxide alarm did not alarm when the licensee initiated a test .

☒ **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, but each separate system was not interconnected.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: Review of the evacuation log indicated all shifts executed the drills during a combined evacuation drill. Drills shall be completed on each shift.