



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 23, 2026

Licensee

Axis Home Health Care LLC
590 Ballytyne Northeast Lane
Spring Lake Park, MN 55432

RE: Project Number(s) SL39903016

Dear Licensee:

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - \$500.00
0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

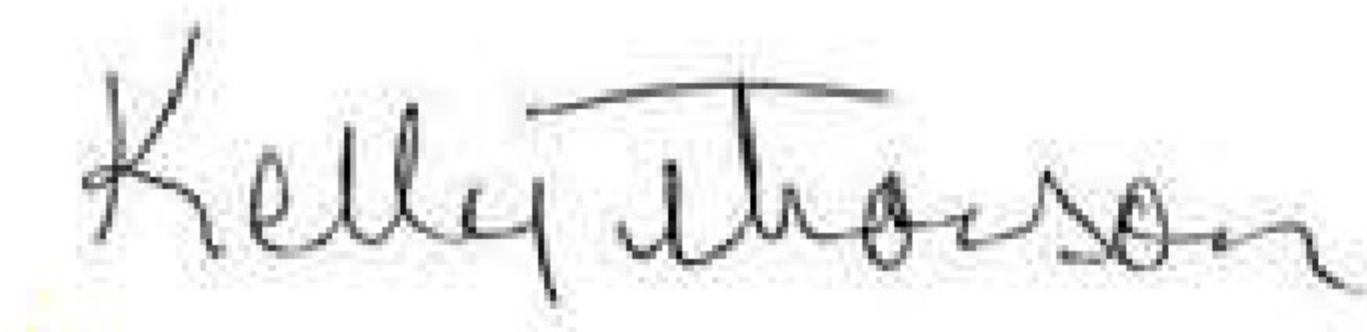
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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,

A handwritten signature in cursive script that reads "Kelly Thorson".

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER AXIS HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 590 BALLYTYNE NORTHEAST LANE SPRING LAKE PARK, MN 55432		
(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: SL39903016-0 On May 18, 2026, through May 21, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 3 residents; 2 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.		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD), licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents receiving Assisted Living 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) 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 held an assisted living facility license issued on May 11, 2026, through May 10, 2027. During the entrance conference on May 18, 2026, at 11:50 a.m., owner (O)-A stated the previous LALD was flagged around a week ago because he was the LALD for too many facilities. She stated they have not had a LALD since that time. On May 18, 2026, at 12:00 p.m. the surveyor	0 110			

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0 110	Continued From page 2 accessed the BELTSS website, it indicated the previous LALD had not been listed as the Director of Record for the facility since October 15, 2025. On May 18, 2026, at 12:05 p.m., O-A stated she was unaware the LALD date as Director of Record ended on October 15, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make available the most recent plan of correction (POC) in a manner readily accessible to residents and others, including	0 345			

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0 345	Continued From page 3 provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders issued for the licensee's survey completed June 5, 2024. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). On June 26, 2024, the licensee was provided with the results of their survey along with form 2567 (a form on which citations are documented with findings of the survey). On May 18, 2026, at 12:50 p.m., the surveyor verbally requested Owner (O)-A provide a copy of the licensee's documented POC related to the previous survey. Additional requests were made via email on May 18, 2026, at 2:22 p.m. and 3:16 p.m. On May 20, 2026, at 1:33 p.m., O-A stated she could not recall where she had placed the POC and had been typing a new POC. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480			

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0 480	Continued From page 4 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean	0 480			

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0 480	Continued From page 5 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 18, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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0 480	Continued From page 6 to the FBEIR for any compliance dates.	0 480			
0 660 SS=D	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 by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test and TB training for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 660			

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0 660	Continued From page 7 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: The facility TB risk assessment completed May 18, 2026, indicated the facility was at a low risk for TB transmission. CNS-B began employment on June 2, 2025, to provide direct care services to residents and supervision of staff. CNS-B's record indicated a chest x-ray had been completed on November 15, 2024, and lacked evidence that a TB baseline screening to include either a TST or a blood test had been completed. In addition, CNS-B's record lacked TB training at time of hire. On May 18, 2026, at 3:30 p.m., owner (O)-A stated CNS-B had completed training before her date of hire at a different facility. On May 19, 2026, at 11:39 a.m., CNS-B provided a Relias (electronic training program) transcript for Catholic Eldercare skilled nursing facility. CNS-B stated she was not aware that it did not meet training requirements. On May 20, 2026, at 12:26 p.m., CNS-B stated she was not aware the chest x-ray did not meet the TB testing requirements. In addition, she stated O-A had discussed completion of the required training with CNS-B, but she did not complete it. CNS-B stated, "to be frank, I started the Educare (electronic training program) but it's repetitive". She stated she completed the same	0 660			

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0 660	Continued From page 8 training for another nursing position she holds and did not realize it was not transferable. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employees' record. The licensee's Tuberculosis Screening / Prevention policy dated April 18, 2023, indicated [the facility] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: Risk Assessment, TB Screening and Staff Education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in	0 700			

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0 700	Continued From page 9 compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two resident's (R1, R2) personal health and medical information was kept private. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 18, 2026, at 12:20 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On March 18, 2026, at 1:30 p.m., the surveyor observed four (4) documents hanging on a bulletin board, located in the living room on the main floor of the facility, that listed R1 and R2's private health information to include: - "R1 will be transferred to a bed in room for changing of his briefs, cares, and bed baths. Please use the EZ stand for transfers for the	0 700			

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0 700	Continued From page 10 safety of you and the client." -"R1 will receive showers and laundry on Saturdays a.m.." -R1's appointment reminder for May 27, 2026, included the date, time, and provider. In addition, it had the following instructions for staff, "make sure he is ready and clean". -"R2 will transfer into his recliner between 7:30 a.m. and 8:00 a.m., he will eat his meals in his recliner, not in bed." On March 20, 2026, at 12:59 p.m., clinical nurse supervisor (CNS)-B stated she was aware the resident's names should not be on the documents hanging on the bulletin board. She stated, "the appointments with the resident names were supposed to be hanging in their rooms, I don't know why staff hung them there". On March 20, 2026, at 1:24 p.m., unlicensed personnel (ULP)-D stated, "two copies are made of all documents hung on the bulletin board. One is hung on the bulletin board, and one is placed in the resident's room". The Minnesota Bill of Rights dated January 1, 2026, noted residents have the right to have personal, financial, health, and medial information kept private. The licensee's Privacy of Protected Health Information dated April 18, 2023, indicated [the facility] shall protect the privacy of its resident's personal health information. No clinical records or personal health information about residents will be accessible in public areas of the office. Papers containing protected health information will be shredded. Staff members who fail to comply with privacy policies and procedures will be disciplined. Continued failure to comply with	0 700			

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NAME OF PROVIDER OR SUPPLIER AXIS HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 590 BALLYTYNE NORTHEAST LANE SPRING LAKE PARK, MN 55432		
(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
0 700	Continued From page 11 privacy practices and procedures may result in termination. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute	0 775			

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0 780	Continued From page 13 Based on observation, record review, and interview, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

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0 800	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810			

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0 810	Continued From page 15 (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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a	0 810			

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0 810	Continued From page 16 violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060			

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01060	Continued From page 17 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01060			

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01060	Continued From page 18 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2 was admitted on January 13, 2026, and began receiving assisted living services. R2's record indicated R2 was hospitalized on April 6, 2026, through April 9, 2026, for chronic obstructive pulmonary disease (COPD) exacerbation and edema. R2's record lacked a written notice provided to R2 including: -the name and contact information for the location to which the resident has been relocated and any new service provider -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. -notify Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On May 20, 2026, at 12:19 a.m., clinical nurse supervisor (CNS)-B stated she was not familiar with the emergency relocation notification	01060			

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01060	Continued From page 19 requirement and had not completed one for any resident at the facility. The licensee's Discharge and Transfer of Residents policy dated April 18, 2023, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: the resident, the resident's legal representatives, the resident's designated representatives, the resident's case manager and if the resident has been relocated and not returned to the facility within four days, the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of	01460			

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01460	Continued From page 20 the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of two employees (clinical nurse supervisor (CNS)-B). 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 potential to affect a large portion or all the residents). The findings include:	01460			

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01460	Continued From page 21 During the entrance conference on May 18, 2026, at 12:28 p.m., owner (O)-A and CNS-B stated the licensee was aware of the required contents in the employee record. CNS-B began employment on June 2, 2025, to provide direct care services to residents and supervision of staff. CNS-B's employee record lacked documentation to indicate CNS-B completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents and supervision of staff. On May 18, 2026, at 3:30 p.m., owner (O)-A stated CNS-B had completed training before her date of hire at a different facility. On May 19, 2026, at 11:39 a.m., CNS-A provided a Relias (electronic training program) transcript for Catholic Eldercare skilled nursing facility. On May 20, 2026, at 12:26 p.m., CNS-B stated O-A had discussed completion of the required training with CNS-B, but she did not complete it. CNS-B stated, "to be frank, I started the Educare (electronic training program) but it's repetitive". She stated she completed the same training for Catholic Eldercare and did not realize it was not transferable. The licensee's Staff Orientation and Education policy dated April 18, 2023, indicated upon hire and before providing service to residents, all employees attend a general orientation conducted by [the facility]. No one may provide direct care to residents on behalf of [the facility] before successfully completing the organization's orientation program.	01460			

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01460	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia, menta All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia, mental illness, and de-escalation training in the required areas for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on May 18, 2026, at 12:28 p.m., owner (O)-A and CNS-B stated the licensee was aware of the required contents in the employee record.	01490			

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01490	Continued From page 23 CNS-B began employment on June 2, 2025, to provide direct care services to residents and supervision of staff. CNS-B's employee file lacked evidence of completing dementia, mental illness, and de-escalation training in the following topics: -person centered planning and service delivery -recognizing symptoms of common mental illness diagnose including but not limited to mood disorders, anxiety disorders, trauma and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse -de-escalation techniques and communication -crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines On May 18, 2026, at 3:30 p.m., owner (O)-A stated CNS-B had completed training before her date of hire at a different facility. On May 19, 2026, at 11:39 a.m., CNS-A provided a Relias (electronic training program) transcript for Catholic Eldercare skilled nursing facility. She stated she was not aware she did not have all the required training. The licensee's Dementia Education policy dated April 18, 2023, indicated supervisors of direct-care staff will have at least eight (8) hours of initial education within 120 working hours of employment start date in the following topics: -an explanation of Alzheimer's Disease and other dementias -assistance with ADL's -problem solving with challenging behaviors -communication skills	01490			

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01490	Continued From page 24 -person-centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490			
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 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	01530			

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01530	Continued From page 25 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 interview and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 120 hours worked for one of two employees (clinical nurse supervisor (CNS)-B). 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 potential to affect a large portion or all the residents). The findings include: During the entrance conference on May 18, 2026, at 12:28 p.m., owner (O)-A and CNS-B stated the licensee was aware of the required contents in the employee record. CNS-B began employment on June 2, 2025, to	01530			

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NAME OF PROVIDER OR SUPPLIER AXIS HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 590 BALLYTYNE NORTHEAST LANE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 26 provide direct care services to residents and supervision of staff. CNS-B's employee record showed documentation of seven and a quarter hours (7.25) of dementia training completed: -caring for the person with dementia: behaviors and communication (1 hour) -the 3 D's: delirium, dementia, and depression (.5 hour) -Alzheimer's Disease and related disorders: activities of daily living (ADL's) and behaviors (1 hour) -dementia care: challenging behaviors and direct care staff (.5 hour) -dementia care: normal aging vs. Alzheimer's/dementia (.5 hour) -Teepa Snow: dementia 101 (.25 hour) -dementia care: performing ADL's (.5 hour) -Alzheimer's Disease and related disorders: communication needs (1 hour) -an overview of quality dementia care (1 hour) -about Alzheimer's Disease and dementia (1 hour) On May 18, 2026, at 3:30 p.m., owner (O)-A stated CNS-B had completed training before her date of hire at a different facility. On May 19, 2026, at 11:39 a.m., CNS-A provided a Relias (electronic training program) transcript for Catholic Eldercare skilled nursing facility and verified she had completed 7.25 hours of dementia for that facility. The licensee's Dementia Education policy dated April 18, 2023, indicated supervisors of direct-care staff will have at least eight (8) hours of initial education within 120 working hours of employment start date in the following topics:	01530			

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01530	Continued From page 27 -an explanation of Alzheimer's Disease and other dementias -assistance with ADL's -problem solving with challenging behaviors -communication skills -person-centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
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 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	01620			

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01620	Continued From page 28 (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 a registered nurse (RN) conducted a change of condition assessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01620			

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01620	Continued From page 29 The findings include: R2 was admitted on January 13, 2026, and began receiving assisted living services. R2's record indicated R2 was admitted to the hospital on April 6, 2026, and returned on April 9, 2026. On April 19, 2026, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration to R2. R2's record did not include a change of condition assessment. On May 20, 2026, at 12:12 p.m., clinical nurse supervisor (CNS)-B stated she did not think she needed to complete an assessment when residents returned from the hospital. The licensee's Assessment and Reassessment policy dated April 18, 2023, indicated an individualized initial evaluation of all new residents receiving assisted living services will be completed by an RN in order to develop a personalized service plan. The assessment shall be revised regularly and as appropriate. Ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident and may be completed by other licensed nurses acting within their scope of licenses. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			

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01640	Continued From page 30	01640			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of 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 service plan was developed for one of two residents (R2). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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).	01640			

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01640	Continued From page 31 The findings include: R2 was admitted on January 13, 2026, and began receiving assisted living services. R2's diagnoses included post-traumatic stress disorder (PTSD) cervical myelopathy, chronic back and neck pain, and essential hypertension. R2's May 2026, daily chores document indicated R2 received assistance with housekeeping, laundry reminders, meals, bathing, dressing, grooming, positioning, transfers, incontinence care, emptying of catheter bag, blood sugar checks, range of motion exercises, behavior management, and medication administration. On May 19, 2026, the surveyor observed unlicensed personnel (ULP)-D provide medication administration to R2. On May 20, 2022, at 1:01 p.m., clinical nurse supervisor (CNS)-B verified R2 lacked a service plan. CNS-B stated she did not complete a service plan for R2 as required. The licensee's Service Plan policy dated April 18, 2023, indicated an individualized service plan is implemented for all residents. Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan will be finalized not later than 14 days after the date home care services are first provided, if not already completed. The service plan must be revised, if needed, based on resident review or reassessment.	01640			

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01640	Continued From page 32 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
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	01730			

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01730	Continued From page 33 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for two of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on April 14, 2024, and began receiving assisted living services. R1's service plan dated June 4, 2024, included medication administration.	01730			

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01730	Continued From page 34 R1's medication assessment dated March 27, 2026, indicated R1 needed assistance with medication administration. On May 19, 2026, at 10:35 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration and complete a blood sugar check for R1. R2 R2 was admitted on January 13, 2026, and began receiving assisted living services. R2 lacked a service plan. R2's May 2026, Medication Administration Record (MAR) indicated R2 received medication administration daily. R2's medication assessment dated April 27, 2026, indicated R2 needed assistance with medication administration. On May 19, 2026, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration to R2. R1 and R2's medication plans lacked 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	01730			

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01730	Continued From page 35 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 -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. -The medication management record must be current and updated when there are any changes. On May 20,2026, at 12:44 p.m., clinical nurse supervisor (CNS)-B stated, "I don't do a medication plan, I need to create a form". The licensee's Service Plan for Medication Management policy indicated [the facility] will prepare and document a medication management plan as part of the service plan for each resident receiving medication management services. The registered nurse (RN) is responsible for preparing and documenting the medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760			

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01760	Continued From page 36 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 observation, interview and record review, the licensee failed to ensure medication administration was documented 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) 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: R1 R1 was admitted on April 14, 2024, and began receiving assisted living services. R1's diagnoses included uncomplicated autistic disorder, major depression, dystonia, essential hypertension, type two (2) diabetes mellitus without complications, and moderate and	01760			

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01760	Continued From page 37 persistent asthma. R1's service plan dated June 4, 2024, included medication administration. On May 19, 2026, at 10:35 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration and complete a blood sugar check for R1. R1's medication record (MAR) dated May 2026, included the following medications: -fluticasone-salmeterol (shortness of breath) 250/50 micrograms (mcg) twice daily -divalproex (bipolar) 50 milligrams (mg) twice daily -amitriptyline (depression) 25 milligrams (mg) daily -montelukast (asthma) 10 mg daily -furosemide (water retention) 20 mg daily R1's medication record lacked documentation of medication administration on May 3, and May 6 - 11, 2026. R2 R2 was admitted on January 13, 2026, and began receiving assisted living services. R2's diagnoses included post-traumatic stress disorder (PTSD) cervical myelopathy, chronic back and neck pain, and essential hypertension. R2 lacked a service plan. R2's May 2026, Medication Administration Record (MAR) indicated R2 received medication administration daily.	01760			

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01760	Continued From page 38 On May 19, 2026, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration to R2. R2's medication record (MAR) dated May 2026, included the following medications: -Stiolto Respimat (asthma) 2.5 mg daily -albuterol (shortness of breath) 90 mcg four times per day R2's record lacked documentation of medication administration May 1 - 19, 2026. On May 20, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-B stated staff were trained correctly on documentation. She stated she has difficulty with several staff not following her directions. CNS-B stated that she educates staff almost daily. On May 20, 2026, at 1:16 p.m., unlicensed personnel (ULP)-D stated she was aware that all medications administered needed to be documented in the medication administration record (MAR). ULP-D stated, "some people don't listen and just don't do it. She (CNS-B) educates us all the time to document". The licensee's Medication Documentation policy dated April 18, 2023, indicated each medication administered by [the facility] staff will be documented in the resident's clinical record. Documentation will be complete, accurate, and legible. Resident needs will be met related to the medication management plan. If the administration of one or more medications was not completed, staff will document the following: -the reason why the medication was not administered -follow-up procedures to meet the resident's	01760			

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01760	Continued From page 39 needs in compliance with the medication management plan -appropriate notification to registered nurse (RN) supervisor or other persons as instructed regarding missed dosages -medication error report, if appropriate No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all 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 potential to affect a large portion or all the residents).	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER AXIS HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 590 BALLYTYNE NORTHEAST LANE SPRING LAKE PARK, MN 55432			
(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
01770	Continued From page 40 The findings include: R1 R1 was admitted on April 15, 2024, and began receiving assisted living services. R1's diagnoses included uncomplicated autistic disorder, major depression, dystonia, essential hypertension, type two (2) diabetes mellitus without complications, and moderate and persistent asthma. R1's service plan dated June 4, 2024, indicated R1 received medication administration daily. On May 19, 2026, at 10:35 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration and complete a blood sugar check for R1. R2 R2 was admitted on January 13, 2026, and began receiving assisted living services. R2's diagnoses included post-traumatic stress disorder (PTSD) cervical myelopathy, chronic back and neck pain, and essential hypertension. R2 lacked a service plan. R2's May 2026, Medication Administration Record (MAR) indicated R2 received medication administration daily. On May 19, 2026, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration to R2. R1 and R2's records lacked medication set-up	01770			

Minnesota Department of Health

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01770	Continued From page 41 documentation to include dates of medication set-up, names of medications, quantity of doses, times to be administered, route of administration, and name of the person completing medication set-up. On May 20, 2026, at 12:35 p.m., clinical nurse supervisor (CNS)-B stated she provides weekly medication set-up for R1 and R2. She stated she was not aware the set-ups needed to be documented. The licensee's Medication Documentation policy date April 18, 2023, indicated [the facility] will document medication set up according to the following: -date of medication set-up -name of medication -quantity of dose -times to be administered -route of administration -name/title of person completing medication set-up No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written	01790			

Minnesota Department of Health

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01790	Continued From page 42 information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before	01790			

Minnesota Department of Health

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01790	Continued From page 43 the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (ULP-D and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: ULP-D began employment on January 18, 2026, to provide direct care services to residents. ULP-E began employment on October 2, 2024, to provide direct care services to residents.	01790			

Minnesota Department of Health

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01790	Continued From page 44 On May 19, 2026, at 8:55 a.m., the surveyor observed ULP-E provide medication administration to R2. ULP-D and ULP-E's employee records lacked documentation of training and competencies for unplanned time away when the RN was not available. On May 20, 2026, at 1:20 p.m., ULP-D stated she did not receive training but had provided residents with their medications for unplanned time away. She stated she placed the resident's medications in a plastic sandwich bag, wrote the time the resident was scheduled to take the medications on the sandwich bag, and reminded them what pocket the medications would be in before they left the facility. ULP-D stated, "I did not document it". On May 20, 2026, at 1:23 p.m., clinical nurse supervisor (CNS)-B stated the ULP's do not provide medications for unplanned times away. CNS-B stated she was not aware of that requirement and had not provided any training. The licensee's Medication Management Plan for Residents Away from Home policy dated April 18, 2023, indicated for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the registered nurse (RN) in a timely manner, the RN may delegate to an unlicensed personnel to provide the medications based on the following: -the RN has trained the unlicensed personnel and determined competency to follow procedures for giving medications to residents -the RN has instructed the unlicensed personnel	01790			

Minnesota Department of Health

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01790	Continued From page 45 to ensure that all appropriate precautions are taken -the RN has developed written procedures/protocols for the unlicensed personnel, including special instructions regarding controlled substances including: -type of container -how the container should be labeled -written information about the medications provided medications to the resident, the number of medications that were provided to the resident -any other information No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. In addition, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had	01880			

Minnesota Department of Health

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01880	Continued From page 46 the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 18, 2026, at 12:24 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On May 19, 2025, at 11:11 a.m., the surveyor, CNS-B, and owner (O)-A observed the main refrigerator located in the kitchen. All resident medications that required refrigeration were in an unsecured refrigerator drawer and lacked a temperature log. The refrigerator contained two (2) Ozempic 2 milligrams (mg)/ 3 milliliters (ml) and three (3) Humulin R U-500 KwikPens for R1. On May 19, 2026, at 11:15 a.m., O-A stated the refrigerator was used to store resident medications. She stated, "the last survey, they told us the refrigerator did not require a temperature log". On May 19, 2026, at 11:17 a.m., CNS-B stated the medications were stored in the refrigerator when she began employment, "I know it was my oversight, and we will fix that". CNS-B stated she was aware only the employees should have	01880			

Minnesota Department of Health

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01880	Continued From page 47 access to medications. The manufacturer's instructions for Ozempic dated April 2019, indicated prior to first use, the medication should be stored in a refrigerator between 36 degrees F (Fahrenheit) to 46 degrees F. Do not freeze Ozempic and do not use Ozempic if it has been frozen. The manufacturer's instructions for Humulin R U-500 dated December 29, 2015, indicated to store all unopened KwikPens in a refrigerator between 36 degrees F (Fahrenheit) to 46 degrees F, not in freezer. Do not use if it has been frozen. The licensee's Storage/Control of Medications policy dated April 18, 2023, indicated medications are stored in a secured medication cabinet and only authorized personnel have access to the stored medications. Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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	01970			

Minnesota Department of Health

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01970	Continued From page 48 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R1) receiving treatments. 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 on April 14, 2024, and began receiving assisted living services. R1's diagnoses included uncomplicated autistic disorder, major depression, dystonia, essential hypertension, type two (2) diabetes mellitus without complications, and moderate and persistent asthma. R1's service plan dated June 4, 2024, included blood glucose monitoring and catheter care. On May 19, 2026, at 10:35 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration and complete a blood sugar check for R1. R1's medical record lacked a physician order for	01970			

Minnesota Department of Health

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01970	Continued From page 49 blood glucose monitoring and catheter care. On May 20, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-B provided a document dated April 17, 2024, titled Accurate Home Care, Care Coordination - Visit Note. CNS-B stated it was the most recent document regarding R1's catheter care. On May 20, 2026, at 11:40 a.m., CNS-B stated they do not have current physician orders for R1's blood glucose monitoring or catheter. She stated she did not obtain the orders as required. The licensee's Prescriber's policy dated April 18, 2023, indicated [the facility] will provide all medically delegated services under an authorized prescriber's order, when indicated. Medication and treatment orders will be renewed at least every year or when changes occur. 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

Axis Home Health Care LLC
590 BALLYTYNE NORTHEAST LANE
Spring Lake Park, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 39903

Risk:
License:
Expires on:
CFPM: Jewri Merchant
CFPM #: 53703; Exp: 10/19/2027

Inspection Info

Report Number: F1025261106
Inspection Type: Full - Single
Date: 5/18/2026 Time: 1:30 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 4-100 Equipment Construction Materials

4-101.18 *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0493 Discontinue using cleaning aids or utensils that can scratch or scour the nonstick coating of pots, pans, griddles, cookie sheets, waffle makers and other cookware.

COMMENT: Pots and pans with damaged nonstick finish placed on countertop, discard and replace. If steel wool will be used for cleaning, replace pots and pans with utensils that have a durable finish e.g. stainless steel.

Comply By: 5/22/2026 Originally Issued On: 5/18/2026

Food & Beverage General Comment

Facility has residential appliances and finishes, tile floor, wood cabinets, and a two compartment sink.

Discussed employee and resident illness and exclusion, food cook temperature with TMD available, checking dish machine temperature with available irreversible strips, handwashing, refrigerator reported recently replaced. Pest control: organize under sink area and remove empty or unused items for better inspection for pests.

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 F1025261106 from 5/18/2026

Establishment Representative

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Axis Home Health Care LLC
Spring Lake Park
County/Group: Anoka County

Inspection Info

Report Number: F1025261106
Inspection Type: Full
Date: 5/18/2026
Time: 1:30 PM

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Food Establishment Inspection Report

 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164	No. of Risk Factor/Intervention/Violations		0	Date: 5/18/2026
	No. of Repeat Risk Factor/Intervention/Violations			Time: 1:30 PM
	Score (optional)			Dur: min
Establishment: Axis Home Health Care LLC	Address: 590 BALLYTYNE NORTHEAST LANE	City/State: Spring Lake Park, MN	Zip: 55432	Phone:
License/Permit #: HFID 39903	Permit Holder:	Purpose of Inspection: Full	Est. Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item					Mark "X" in appropriate box for COS and/or R				
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					COS=corrected on-site during inspection R=repeat violation				
Compliance Status			COS	R	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	IN	Certified Food Protection Manager			19	N/O	Proper reheating procedures for hot holding		
Employee Health					20	N/O	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	N/O	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	IN	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	IN	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	IN	Hands clean and properly washed			26	IN	Pasteurized foods used; prohibited foods not offered		
9	IN	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	IN	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	IN	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	IN	Food separated and protected							
16	IN	Food-contact surfaces; cleaned & sanitized							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation									
			COS	R				COS	R
Safe Food and Water					Proper Use of Utensils				
30	N/A	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/O	Plant food properly cooked for hot holding			47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48		Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
					58		Compliance with licensing and plan review		

Inspector (signature)	Follow-up:	Follow-up Date:
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Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39903016-0	Date: May 19, 2026
Facility Name: Axis Home Health Care LLC	
Facility Address: 590 Ballytyne Northeast Lane, Spring Lake Park, MN 55432	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. A means of egress shall be free from obstructions that would prevent its use. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments:

- The egress window handle was broken in unoccupied resident room two, which made opening this emergency escape window slow and difficult. Egress window hardware that does not work properly would delay escape in the event of an emergency.
- The floor plans displayed in the building identified bedroom five in the basement. Assisted program director (APD)-C stated this room was currently used as an office. When the egress window in unoccupied bedroom five was opened by APD-C, the emergency escape and rescue opening was obstructed by a window well cover held down by a fence gate. When window well covers and/or fall prevention guards are installed, these components must not impede the use of the egress window for escape and rescue.

3. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

Comments: The vent was disconnected from the clothes dryer in the basement utility room and there was an accumulation of lint behind the clothes dryer, creating a fire hazard.

4. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: On the exterior of the building in the designated smoking area near the front door, burnt cigarettes had been discarded on the lawn and in the landscaping rocks.

5. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

Comments: Two power strips were daisy chained together at the employee workstation in the main floor living room, creating an electrical fire hazard.

6. Compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 5303.5.3]

Comments: One oxygen cylinder was stored on the floor in the detached garage. This oxygen cylinder was not stored in a rack.

7. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: Empty hardwired smoke alarm harnesses were observed in the basement and on the main floor of the building. Hardwired smoke alarms must be maintained where installed previously.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

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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:

- Assisted program director (APD)-C stated battery operated wireless smoke alarms had been installed to meet the statute requirements. When APD-C tested the wireless smoke alarms on the main floor, the alarms installed in the basement were not actuated. When APD-C tested the wireless smoke alarms in the basement, the main floor smoke alarms were not actuated. All of the battery operated wireless smoke alarms were not interconnected.

- When APD-C tested the battery operated wireless smoke alarms, the hardwired smoke alarms were not actuated. All dwelling unit smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments:

- In occupied resident bedroom one, the cover was missing from the ceiling fan light fixture.
- In occupied resident bedrooms three and four, there were several holes in the doors.
- In the main floor bathroom, there was a small hole at the base of the door and the drywall surface was chipped on the wall adjacent to the shower stall.
- The storm door and the kitchen window screens were torn on the back of the building.
- The paint was peeling, and wood surfaces were noted as rough on the front and back decks with access ramps. Additionally, the wood was splintered and deteriorated on the top surface of one back deck handrail.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The emergency evacuation floor plans displayed in the building identified bedroom five in the basement. Assisted program director (APD)-C stated this room was an office and would not be used as a bedroom because it was too small. Emergency evacuation floor plans shall accurately identify all resident bedrooms to provide efficient communication for exiting in the event of a fire or similar emergency.

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

Comments:

- The fire safety and evacuation plan (FSEP) included standard employee protocols but failed to include specific employee actions for the facility.
- The FSEP included an emergency action plan. The emergency action plan contact phone numbers for fire, paramedics, ambulance, the building manager, and utility companies were blank.
- Employees were inaccurately instructed to use pull fire alarms.

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

Comments: The fire safety and evacuation plan (FSEP) failed to include site specific fire safety and evacuation instructions for residents.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee stated two residents had been identified as requiring employee assistance in the event of an evacuation. Individualized evacuation procedures for these residents were not included with the fire safety and evacuation plan.

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

Comments: The surveyor requested records for employee training on the fire safety and evacuation plan (FSEP) completed at the time of hire and in the last year from the licensee. Employee FSEP training records were not provided for review when requested. The licensee stated employees were trained during fire drills. Employee training on the FSEP was not completed at the required frequency.

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for resident training on fire safety and evacuation completed in the last year from the licensee. One training record for the emergency action plan, dated July 2024, for three residents, was provided. Residents were not trained on fire safety and evacuation at the required frequency.

7. 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: The surveyor requested records for all evacuation drills completed in 2025 and 2026, from the licensee. Fire drill logs were provided indicating drills were completed in January, July, and December of 2025, and in March 2026. The fire drill logs failed to include the time or shift of the drill. The fire drill logs lacked the simulated fire locations and drill conditions. The fire drill logs inaccurately recorded that smoke compartments had been evacuated. The licensee had inappropriately combined employee shifts for all of the 2025 and 2026 drills. Evacuation drills had not been completed at the

required frequency and the fire drill documentation lacked information needed to evaluate regulatory compliance.