



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 19, 2025

Licensee
Jacob Services LLC
1086 Highview Drive
New Brighton, MN 55112

RE: Project Number(s) SL40687015

Dear Licensee:

On November 12, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on May 16, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 8, 2025

Licensee

Jacob Services LLC

1086 Highview Drive

New Brighton, MN 55112

RE: Project Number(s) SL40687015

Dear Licensee:

On August 26, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 16, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 16, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 16, 2025, found not corrected at the time of the August 26, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - \$500.00

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

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on August 26, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on August 26, 2025, we identified the following violation(s):

0130-Application For Licensure-144g.12, Subd. 1

0330-Information Provided By Facility-144g.30 Subd. 4

0650-Staff Records-144g.42 Subd. 8 (a)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/26/2025
NAME OF PROVIDER OR SUPPLIER JACOB SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1086 HIGHVIEW DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL40687015-1 On August 5, 2025, through August 26, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 16, 2025. At the time of the survey, there were two (2) residents; 2 receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 130 SS=F	144G.12, Subd. 1 Application for Licensure	0 130			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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

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0 130	Continued From page 3 Regulations, title 42, section 1001.101 or 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted,	0 130			

Minnesota Department of Health

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0 130	Continued From page 4 conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the definition of an assisted living facility when the licensee had non-resident individuals with no assisted living contracts residing at the location. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held a provisional assisted living license effective February 14, 2024, with expiration date of February 13, 2025. During the survey follow-up facility tour on August 11, 2025, at 10:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had the same two residents. LALD/CNS-A stated unlicensed personnel (ULP)-C was hired on May 15, 2025. ULP-C	0 130			

Minnesota Department of Health

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0 130	Continued From page 5 stated she worked full-time, Monday through Friday from 8:00 a.m. to 5:00 p.m. or 8:00 p.m., depending on if ULP-B requested ULP-C to stay longer. LALD/CNS-A later stated ULP-C worked overnights (awake). The surveyor observed a rambler style home with three bedrooms upstairs and three bedrooms downstairs. Two of the three bedrooms upstairs were occupied by R1 and R2. On the lower level, the bedroom directly across from the laundry room had a twin sized bed with pillow and comforter, and personal items (opened laptop, purse, and deodorant) on the desk next to the bed. The second bedroom on the lower level directly off the living room area had a twin sized bed with clothes piled on it and closed suitcases on the floor propped upright. LALD/CNS-A stated the clothes and suitcases were her items. The third bedroom was the largest and was not previously identified as a bedroom because there was no bed. During this tour, the largest bedroom now had a full- or queen-sized bed with bedding on a black padded frame, bookcase full of books, desk with personal items, and treadmill. The lower-level bathroom had multiple bottles of soap in the shower. LALD/CNS-A stated she had her own apartment that was "very far away," and denied living at the licensee's facility. LALD/CNS-A stated she stayed the night and the personal items in the other room (laptop, purse) belonged to ULP-C. LALD/CNS-A denied ULP-C slept there but could not explain why the room appeared to be lived in. On August 11, 2025, at 10:40 a.m., the surveyor requested completed timesheets or staff schedule. LALD/CNS-A stated they did not have either available. LALD/CNS-A stated the licensee's process was for ULP-B to inform LALD/CNS-A by email of everyone's hours	0 130			

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0 130	Continued From page 6 worked to process payroll. On August 11, 2025, at 11:03 a.m., the surveyor interviewed R1 and R2. Both R1 and R2 stated ULP-C worked all the time. R1 was unable to go downstairs due to his physical limitations and R2 stated he only went downstairs to use the bathroom if the bathroom upstairs was in use. He did not use the treadmill. During interview on August 11, 2025, at 11:07 a.m., ULP-C apologized for informing the surveyor the hours she worked (Monday through Friday, day hours) was when ULP-B was on leave. ULP-C stated currently she worked overnights (12-hour shifts) and did not have a car so she would use "Uber" for a ride or LALD/CNS-A would pick her up so it was easier to have her personal items there and stayed the night. Minnesota Assisted Living Statutes 144G.08 definitions dated 2024, indicated: - Subd. 2. Adult - "Adult" means a natural person who has attained the age of eighteen years. - Subd. 5. Assisted living contract - "Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services;" - Subd. 7. Assisted living facility - "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions. - Subd. 59. Resident - "Resident" means an adult living in an assisted living facility who has executed an assisted living contract.	0 130			

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0 130	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130			
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a follow-up survey. 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 a provisional assisted living	0 330			

Minnesota Department of Health

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0 330	Continued From page 8 facility license effective February 14, 2024, with an expiration date of February 13, 2025. During the onsite survey follow-up on August 11, 2025, at 10:09 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and unlicensed personnel (ULP)-C onsite. ULP-C stated she was working that day. LALD/CNS-A stated ULP-C was hired on May 15, 2025 (part of correction plan to mitigate staffing issues) and ULP-B still worked for licensee. ULP-C explained to the surveyor that she worked full-time Monday through Friday from 8:00 a.m. to 5:00 p.m. or 8:00 p.m., depending on need and worked weekends only when LALD/CNS-A needed her. When ULP-C was not in proximity, LALD/CNS-A stated ULP-C worked awake overnight shifts. LALD/CNS-A stated she stayed at the facility while ULP-C worked overnight shifts due to ULP-C having anxiety. LALD/CNS-A then explained ULP-C's training has been very slow due to ULP-C not having prior experience but deemed ULP-C competent to administer medications to the licensee's residents but required continued supervision. The surveyor observed the lower level with LALD/CNS-A. The bedroom directly across from the laundry room had a twin sized bed with pillow and comforter, and personal items (opened laptop, purse, and deodorant) on the desk next to the bed. The second bedroom on the lower level directly off the living room area had a twin sized bed with clothes piled on it and closed suitcases on the floor propped upright. LALD/CNS-A stated the clothes and suitcases were hers. The third bedroom was the largest and was not previously identified as a bedroom because there was no bed. During this tour, the largest bedroom now	0 330			

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0 330	Continued From page 9 had a full- or queen-sized bed with bedding on a black padded frame, bookcase full of books, desk with personal items, and treadmill. The lower-level bathroom had multiple bottles of soap in the shower. LALD/CNS-A stated she had her own apartment that was "very far away," and denied living there. LALD/CNS-A stated she stayed the night and stated the personal items in the other room (laptop, purse) belonged to ULP-C. LALD/CNS-A denied ULP-C slept there but could not explain why the room appeared to be lived in. LALD/CNS-A explained she needed to hire more ULPs but applicants had been wanting an hourly wage she could not afford to pay, but once she admitted a third resident, she would be able to pay more per hour. On August 11, 2025, at 10:40 a.m., the surveyor requested timesheets or schedules to confirm who worked the overnight shifts. LALD/CNS-A stated she did not have the staff schedule or timesheets available, instead LALD/CNS-A was emailed the hours ULP-B and ULP-C worked to complete payroll. LALD/CNS-A stated she would search her email inbox to find the requested information. R2's Service Recap Summary-Month dated July 1, through August 10, 2025, included documentation of services provided by LALD/CNS-A and ULP-C (no documentation by ULP-B) at the following times: 8:00 a.m., AM (day), midday, 12:00 p.m., evening, 8:00 p.m., bedtime, and overnight. The documentation record also included the following information: -ULP-C initialed under "AM" shift 32 out of 41 days (one day was blank); -ULP-C initialed under "evening" shift 27 out of 37 days (four days were blank);	0 330			

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0 330	Continued From page 10 -ULP-C initialed under "bedtime" shift 14 out of 33 days (eight days were blank); -ULP-C initialed under "overnight" shift 5 out of 26 days (fifteen days were blank); and -ULP-C initialed on every shift (day, evening, and overnight) on July 22, and 29, 2025, August 6, 8, and 10, 2025 (the surveyor observed ULP-C on site on August 11, 2025). During interview on August 11, 2025, at 11:03 a.m., R1 stated ULP-C "was there all the time." R1 was unable to specify who worked overnight shifts. During interview on August 11, 2025, at 11:07 a.m., ULP-C stated she typically worked overnights (12-hour shifts) and apologized for giving the surveyor the incorrect schedule. ULP-C explained when ULP-B had a leave of absence, she worked ULP-B's hours (day hours). ULP-C did not have a car so she had to use "Uber" for rides or LALD/CNS-A would pick her up so it was easier to have her personal items at the facility and she stayed the night. During interview on August 11, 2025, at 11:10 p.m., the surveyor requested LALD/CNS-A the current weeks schedule, and she stated "tonight overnight will be [name of ULP-B], then Tuesday morning is me [LALD/CNS-A] for half day, then for second half of the day will be [name of ULP-B]. Tuesday overnight will be [name ULP-C]." LALD/CNS-A did not know the schedule for the remainder of that week. During interview on August 11, 2025, at 12:00 p.m., the surveyor asked why R1 and R2's service documentation and medication administration record for the month of July and	0 330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/26/2025
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0 330	Continued From page 11 August only showed LALD/CNS-A and ULP-C's initials, LALD/CNS-A stated ULP-B was working but was training ULP-C so ULP-C was doing all the charting. During interview on August 11, 2025, at 12:41 p.m., ULP-C stated she began training middle of June, trained a little with ULP-B before ULP-B left for vacation. ULP-B taught resident cares and LALD/CNS-A taught medication administration. ULP-C stated she was not left alone for a long period of time, but after two weeks of training, she was more on her own. ULP-C stated ULP-B left mid-June and came back July 23 and is back to work. ULP-C stated on the resident electronic health record (Residex), she signed in every time she started her shift. LALD/CNS-A did not provide the surveyor with hours each ULP worked by the time the survey was completed. Throughout the survey, the surveyor was given conflicting information regarding staff schedule, whether staff had been staying at the facility, and the completion of ULP-C's training. It was also unclear how both ULP-B and ULP-C worked the same shifts for training (three months after hire) when the licensee had difficulty hiring staff due to wage requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 12 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 13 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 11, 2025, at 10:09 a.m., the surveyor observed unlicensed personnel (ULP)-C at the facility working the day shift. ULP-C stated she worked Monday through Friday from 8:00 a.m. to 8:00 p.m., and worked some weekends if needed. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she worked some weekends and was on site when ULP-C worked overnights. On August 11, 2025, at 10:40 a.m., the surveyor requested timesheets or schedules to confirm who worked the overnight shifts. LALD/CNS-A stated she did not have the staff schedule or timesheets available, instead LALD/CNS-A was emailed the hours ULP-B and ULP-C worked to complete payroll. LALD/CNS-A stated she would search her email inbox to find the requested information. On August 11, 2025, at 11:07 a.m., ULP-C stated she typically worked overnight shifts (12-hour shifts) and apologized for telling the surveyor she worked Monday through Friday day shifts. On August 11, 2025, at 11:10 a.m., the surveyor observed the daily staffing schedule posted on a whiteboard within the living room dated "6/20/2025-7/20/2025," then showed columns for each day of the week and four rows representing	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 14 four weeks. Each day of the week listed two (2) 12-hour shifts: 8:00 a.m. through 8:00 p.m. and 8:00 p.m. through 8:00 a.m. and titles (home health aide (HHA), registered nurse (RN)) for each shift. Some days of the month were illegible because the dry erase marker was smudged or rubbed off. LALD/CNS-A stated ULP-B was going to work the overnight shift that day, then for the following day (August 12, 2025) morning shift, she was going to work half shift then ULP-B would work the remainder of day shift, then ULP-C would work overnight shift (8:00 p.m. through 8:00 a.m.). LALD/CNS-A did not know the schedule for the remainder of the week. On August 11, 2025, at 11:28 a.m., the surveyor observed the daily staffing schedule posted and noted the dates were changed to "7/20/2025-8/20/25," and the rest of the board remained the same. The licensee's Staffing policy dated December 11, 2024, indicated the daily staffing schedule was prepared by the CNS and addresses: -home health aide work schedules for each home health aide showing all work shifts with days/hours worked; and -the home health aide's resident assignments or work location. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 15 from public disclosure. No further information was provided.	{0 470}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	0 650	Not reviewed during this survey.		

Minnesota Department of Health

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0 650	Continued From page 16 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 11, 2025, at 10:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C's hire date was May 15, 2025, and showed the surveyor ULP-C's profile on their electronic health record (Residex) confirming the date stated.	0 650			

Minnesota Department of Health

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0 650	Continued From page 17 On August 11, 2025, at 11:46 a.m., the surveyor asked LALD/CNS-A for ULP-C's personnel record, LALD/CNS-A stated ULP-B had ULP-C's record as she was training her. On August 11, 2025, at 12:09 p.m., the surveyor requested ULP-C's medication competency, and LALD/CNS-A stated ULP-C had her entire record including competencies and training at home because ULP-C was still working on her tests for infection control, and dementia. ULP-C's personnel record included a negative tuberculosis (TB) QuantiFERON Gold Plus (blood test) dated May 16, 2025. ULP-C's record also included a 30-day supervision providing a delegated task dated June 16, 2025. ULP-C's personnel file lacked the following required content: -records of orientation, required infection control training, and competency evaluations; -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; -for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings (missing the TB health history screen); and -documentation of the background study as required under section 144.057. During interview on August 11, 2025, at 12:41 p.m., ULP-C stated she began training middle of June, trained with ULP-B on resident cares and LALD/CNS-A trained her on medication administration. ULP-C stated she left her training records at home.	0 650			

Minnesota Department of Health

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0 650	Continued From page 18 The licensee's Personnel Records policy dated December 11, 2024, indicated a record of each paid employee, regularly scheduled volunteer providing assisted living services would be maintained. The policy also indicated a personnel record would include results of background studies, infection control training, documentation of orientation, signed job description, and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}			
			Not reviewed during this survey.		

Minnesota Department of Health

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{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}			
{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:	{0 775}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 775}	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 4, 2025, at 8:08 a.m., the surveyor emailed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and requested a plan of correction for the 0775 tag for physical environment orders issued pursuant to a survey completed on May 15, 2025. Photos and/or documentation to support corrective actions were requested. The surveyor requested the above listed information be provided no later than 4:00 pm on August 5, 2025. On August 5, 2025, at 1:07 p.m., LALD/CNS-A responded we have fixed the tag, our residents use the backyard to smoke and the ashtray is on concrete, we also took care of the garage area. No photos or documentation were provided. A plan of correction was not provided. On August 5, 2025, at 2:18 p.m., the surveyor emailed LALD/CNS-A and requested photos of the designated smoking area and garage wall be provided no later than 6:00 p.m. on August 5, 2025. On August 8, 2025,	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 21 at 12:07 p.m., LALD/CNS-A emailed the surveyor one photo of the garage wall access panel and one photo of the designed smoking area in the backyard patio. The photo of the garage wall access panel indicated there was a gap between the wall and the panel; and there was a hole in the wall adjacent to the panel. The photo of the designated smoking area indicated there was an open ashtray containing burnt cigarettes and a black smoking material disposal receptacle designed for use in a vehicle cup holder, both containers were stored on a table. On August 11, 2025, at 10:02 a.m., the surveyor entered the facility and observed R1 on the wood ramp outside the front door smoking. An open ashtray filled with used burnt cigarettes was stored on the wood ramp, and one burnt cigarette was lying directly on the wood next to the ashtray. Additionally, a tin container was stored on the floor of the wood ramp. In the smoking area on the patio in the backyard, an open ashtray containing burnt cigarettes was stored on a table. Two burnt cigarettes had been placed in the grooves on the outer edge of this ashtray. A black smoking material disposal receptacle designed for use in a vehicle cup holder was also stored on the patio table. Covered disposal receptacles of an approved style and of sufficient size shall be provided in all designed smoking areas. On August 11, 2025, at 10:07 a.m., the surveyor toured the attached garage and observed the access panel was not secured to the side wall and gaps were present between the fire-resistant wall of the occupied assisted living dwelling unit and the attached garage. Additionally, there was a hole in the wall at the upper right corner of the	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 22 panel. The fire-resistant wall on the garage side between the dwelling unit and the attached garage is required to be maintained free of holes and gaps, and be sealed to prevent the passage of smoke or fire from one side of the wall to the other. During an interview on September 8, 2025, at 11:35 a.m., LALD/CNS-A stated two new disposal containers had been purchased for smoking material disposal and the owner of the house had already repaired the wall in the garage.	{0 775}			
{0 800} SS=F	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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the 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	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 23 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 11, 2025, at 10:02 a.m., the surveyor entered the facility and observed in the designated outdoor space for residents in the backyard and along the foundation on the back of the house, there were overgrown weeds and grass, creating a harborage area for pests. During an interview on September 8, 2025, at 11:35 a.m., LALD/CNS-A verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days Previous survey findings not reviewed during this survey: On May 15, 2025, at 12:20 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed the following: - In the basement bedrooms, storage room, and living room: Adhesive had oozed out between the laminate floor tiles, creating a sticky floor surface. The spaces between the floor tiles were soiled. Base trim and lower wall surfaces were soiled and water stained. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the above listed basement observations and stated water had leaked into the basement when the pump stopped working. LALD/CNS-A stated the pump	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 24 had been fixed but the damaged surfaces had not yet been repaired. - Screen door hardware was installed and hanging loose from the top of the frame for the back door. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the above listed door observation and stated the screen door broke and had been removed as a result.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique 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	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 25 drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{0 900} SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated	{0 900}			

Minnesota Department of Health

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{0 900}	Continued From page 26 representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}	Not reviewed during this survey.		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}			
{01530} SS=D	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	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 27 paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		

Minnesota Department of Health

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{01560}	Continued From page 28	{01560}			
{01560} SS=C	144G.64 (a; 5), (b) Training in Dementia, Mental Illness, and De- (5) new staff members may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required dementia, mental illness, and de-escalation training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; (5) person-centered planning and service delivery; (6) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (7) de-escalation techniques and communication; and (8) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. This MN Requirement is not met as evidenced by:	{01560}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}	Not reviewed during this survey.		

Minnesota Department of Health

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{01620}	Continued From page 29 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living 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	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 30 on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.		
{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.	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 31 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.		
{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	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 32 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be 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:	{01730}	Not reviewed during this survey.		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 33 by:	{01760}	Not reviewed during this survey.		
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	{01820}	Not reviewed during this survey.		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}	Not reviewed during this survey.		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states:	{03090}	Not reviewed during this survey.		

Minnesota Department of Health

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{03090}	Continued From page 34 "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	{03090}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 11, 2025

Licensee
Jacob Services LLC
1086 Highview Drive
New Brighton, MN 55112

RE: Project Number(s) SL40687015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 16, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

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

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

The total amount you are assessed is \$500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per 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 residents/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 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 the Department of Health 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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER JACOB SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1086 HIGHVIEW DRIVE NEW BRIGHTON, MN 55112		
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40687015-0 On May 12, 2025, through May 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two (2) residents; all received services under the Assisted Living Facility license. On May 15, 2025, an immediate correction order was issued for tag identification 0470. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more awake staff were available in the assisted living, 24 hours per day, seven days per week, to be responsible for responding to the requests of residents for assistance with health or safety needs. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

Minnesota Department of Health

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 12, 2025, at 10:54 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had two 12 hours shifts; days from 8:00 a.m. to 8:00 p.m., and nights from 8:00 p.m. to 8:00 a.m. LALD/CNS-A explained she worked about three days per week during the day performing different tasks then also worked all overnight shifts until she could find staff to over those shifts. LALD/CNS-A also stated she supervised another facility unrelated to licensee as the LALD and CNS. During facility tour with LALD/CNS-A on May 12, 2025, at 1:10 p.m., the surveyor observed a rambler style home with three bedrooms upstairs and two bedrooms downstairs. Two of the three bedrooms were occupied by R1 and R2. On the lower level, the bedroom directly across from the laundry room had a twin sized bed with pillow and comforter, and personal items on the desk next to the bed. The other unoccupied bedroom on the lower level had a twin sized bed with sheets and folded blanket. The surveyor asked LALD/CNS-A if she was sleeping in the bedroom across the laundry room, she explained she slept upstairs on the couch overnight so she would be able to hear the residents' call light. R1 had diagnoses of cerebral vascular accident	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 (stroke), spinal osteochondrosis (degenerative changes in the intervertebral discs of the spine), and frequent loose stools alternating with constipation. R1's Master Care Plan dated February 20, 2025, indicated R1 received assistance with medication management, compression stockings, dressing, showers, meals, and behavior management. On May 12, 2025, at 1:50 p.m., R1 stated response time was prompt during the night if he activated the call light. The surveyor observed R1 to have his cellphone on his person. R2 had diagnoses of diabetes mellitus type II, high cholesterol, and opioid abuse. R2's Master Care Plan dated May 13, 2025, indicated R2 received assistance with medication management, laundry, housekeeping, meals, and behavior management. On May 13, 2025, at 10:25 a.m., R2 stated he typically did not get up during the night and did not have any issues with staff response time. R2 was unsure where overnight staff slept but did indicate they slept on the overnight shift. The licensee's undated Facility Staffing Plan indicated the licensee would provide an adequate number of qualified awake direct-care staff to meet resident needs 24 hours a day, seven days a week. The current staffing model, included in the staffing plan, indicated there would be at least one employee on every shift. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470			

Minnesota Department of Health

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0 470	Continued From page 4 Based on interview and record review, the licensee failed ensure their staffing plan included an evaluation, to be conducted at least twice annually. The findings include: On May 12, 2025, at 11:39 a.m., during the entrance conference, the surveyor asked LALD/CNS-A if they had developed and implemented a staffing plan, she stated "no, do not have it." During record review, the surveyor located an undated Facility Staffing Plan, which indicated Monday through Sunday from 7:00 a.m. to 7:00 p.m. (day shift), and 7:00 p.m. to 7:00 a.m. (night shift), one direct care staff would be scheduled, and LALD/CNS-A would be available 24 hours per day, seven days a week. During exit conference on May 16, 2025, at 9:00 a.m., LALD/CNS-A stated she was unaware that documenting an evaluation of the resident's needs was required when the plan was implemented. The licensee's Staffing policy dated December 11, 2024, indicated the staffing plan was based on an evaluation of the appropriateness of the staffing levels in the facility and would be reviewed at least twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

Minnesota Department of Health

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0 630	Continued From page 5	0 630			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 had diagnoses of cerebral vascular accident (stroke), spinal osteochondrosis (degenerative changes in the intervertebral discs of the spine), and frequent loose stools alternating with	0 630			

Minnesota Department of Health

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0 630	Continued From page 6 constipation. Throughout the survey, the surveyor observed unlicensed personnel (ULP)-B provide medication administration, assist with dressing, provide meals, and apply compression stockings. R1 walked around within the facility and outside with his four-wheel walker and smoked frequently outside. R1's Master Care Plan dated February 20, 2025, indicated R1 received assistance with medication management, compression stockings, dressing, showers, meals, and behavior management. R1's Assessment by Date (nursing assessment) dated February 20, 2025, noted R1 was at risk to be abused by others and self-abuse and indicated licensee's staff were responsible to keep R1 safe from abuse of all kinds. The IAPP indicated R1 had frequent agitation and verbal aggression, however, the IAPP lacked whether R1 was susceptible to abuse other individuals and statements of specific measures to be taken to minimize that risk. On May 13, 2025, at 2:44 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she did not believe the residents were at risk to abuse others, so she did not include that information in the nursing assessment. The licensee's Vulnerable Adult Policy dated December 11, 2024, indicated the licensee would assess the vulnerability status of each resident upon admission. The IAPP shall contain an assessment of the resident's susceptibility to abuse by another individual, risk of abusing other vulnerable adults, and shall contain statements of	0 630			

Minnesota Department of Health

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0 630	Continued From page 7 specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing for one of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A).	0 660			

Minnesota Department of Health

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0 660	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment was completed January 20, 2025, and indicated the facility was at a low risk for TB transmission. On May 12, through May 14, 2025, the surveyor observed LALD/CNS-A at the facility participate in the survey, provide direction to unlicensed personnel (ULP)-B, and interact with residents. On May 12, 2025, at 10:54 a.m., during the entrance conference, LALD/CNS-A stated the licensee had two 12-hour shifts; days from 8:00 a.m. to 8:00 p.m., and nights from 8:00 p.m. to 8:00 a.m. LALD/CNS-A explained she worked about three days per week during the day performing supervision and nursing tasks then also worked all overnight shifts providing direct care to all residents. LALD/CNS-A was hired on January 13, 2025. LALD/CNS-A's employee record included a TB Screening Questionnaire dated February 27, 2025, and a positive TB Quantiferon Gold Plus exam dated March 5, 2025, which recommended a one (1) view chest x-ray (CXR) and virtual clinician visit.	0 660			

Minnesota Department of Health

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0 660	Continued From page 9 LALD/CNS-A employee record lacked documentation of completed CXR with provider evaluation, indicating LALD/CNS-A was cleared to work directly with residents. On May 12, 2025, at 3:55 p.m., LALD/CNS-A stated she had the same issue for a survey completed at a different licensee, so she completed the TB Gold test which came to be positive but her provider verbally advised against the CXR because she had a negative CXR from 2022. LALD/CNS-A was unable to produce documentation of the provider's recommendation. The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) last updated on December 13, 2024, indicated "A CXR alone is not acceptable documentation. You either need -documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay test (IGRA), and -a CXR with provider evaluation after that date Or -documentation of refusal of both the two-test TST and IGRA -followed by a new CXR and provider evaluation." The licensee's Tuberculosis Screening/Prevention policy dated December 11, 2024, indicated if employees with a newly identified positive tuberculin skin test (TST) or TB blood test must be assessed for current TB symptoms and risk factors for progression to active TB disease, obtain a CXR to exclude a diagnosis of active infectious TB disease before direct resident contact, and include results in the employee's record.	0 660			

Minnesota Department of Health

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0 660	Continued From page 10 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the	0 680			

Minnesota Department of Health

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0 680	Continued From page 11 required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan, effective date December 11, 2024, lacked the following required content: -Maintain and Annual Emergency Program Updates -missing resident plan (lacked documentation of quarterly review) -not all hazards identified on HVA were included (winter storms/power outage); - Emergency Preparedness Program Patient Population -emergency information for R1 and R2 did not identify service and behavioral health needs; -Development of Emergency Preparedness Policies and Procedures (P/P); -Subsistence Needs for Staff and Patients -minimum food, water, and pharmaceutical supplies, alternate sources of energy to maintain temperatures and lighting, and sewage and waste disposal; -Procedures for Tracking of Staff and Patients; -Policies and Procedures Including Evacuation; -Policies and Procedures for Sheltering -having sufficient resources in supply for	0 680			

Minnesota Department of Health

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0 680	Continued From page 12 shelter-in-place; -Policies and Procedures for Medical Documents; -Policies and Procedures for Volunteers; -Arrangement with Other Facilities -lacked arrangement agreement with other facilities; -Development of Communication Plan -address listed had incorrect house number -lacked alternate plan if phone system failed -lacked transportation plans for evacuation; -Names and Contact Information; -Primary and Alternate Means for Communication; and -Methods for Sharing Information. During interview on May 14, 2025, at 11:20 a.m., unlicensed personnel (ULP)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they would use water from the refrigerator dispenser and stated they did not have bottled water available. They showed the surveyor one flashlight that was available. They did not have an emergency kit as stated in the EPP but showed the surveyor their first aid kit. At 2:02 p.m., LALD/CNS-A verified their EPP had general information and was not tailored to meet the needs of their staff and residents of the licensee. LALD/CNS-A also verified it lacked some required content and thought the missing resident plan needed to be reviewed every six months. LALD/CNS-A verified each resident's emergency preparedness plan was missing pertinent information to evacuate safely. The licensee's Emergency Preparedness policy effective December 11, 2024, indicated the licensee would have an identified plan in place to ensure the safety and well-being of residents and staff during periods of an emergency or a disaster that disrupts facility services.	0 680			

Minnesota Department of Health

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0 680	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 15, 2025, at 12:20 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed the following: EGRESS WINDOWS	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER JACOB SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 HIGHVIEW DRIVE NEW BRIGHTON, MN 55112			
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0 775	Continued From page 14 Egress windows in resident bedrooms were opened by LALD/CNS-A and measured by the surveyor. The designated egress window in unoccupied resident bedroom 1 did not meet the minimum requirements for safe egress. The clear open area of this casement egress window when opened ninety degrees, measured 19 inches in width and 35 1/4 inches in height. The window hardware obstructed the clear open width of the window. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the egress window measurements and stated this was a new egress window installed after the plan review inspection had been completed. One window in each existing resident bedroom must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. SMOKING MATERIAL DISPOSAL A ramp constructed of wood was installed for the front door. Burnt cigarettes had been disposed of in an open shallow ashtray stored on the ramp railing. Burnt cigarettes were also disposed of inside a tin can with a plastic lid stored on the floor of the ramp. Improper disposal of smoking materials creates a fire hazard. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the above listed smoking material disposal observations. FIRE-RESISTANT WALL MAINTENANCE In the attached garage, the attic access panel was not secured to the side wall and gaps were present between the fire-resistant wall of the occupied assisted living dwelling unit and the attached garage. The fire-resistant wall on the garage side between the dwelling unit and the attached garage is required to be maintained free	0 775			

Minnesota Department of Health

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0 775	Continued From page 15 of holes and gaps, and be sealed to prevent the passage of smoke or fire from one side of the wall to the other. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the above listed fire-resistant wall observations. OBSTRUCTED EGRESS - The posted fire safety and evacuation basement floor plan labeled an egress window in bedroom 6. A cover was installed over the window well opening for this designated egress window. The window well cover prevented the egress window from opening to provide the required clear open area for emergency escape. When window well covers are installed, the covering shall not interfere with the opening of the egress window in any way. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the above listed window well cover observation and stated this room was currently designated and only used for storage. - The back door was designated as an exit. This door exited into the backyard, enclosed by a fence with a locked gate. Egress paths leading to the public way from an exit door shall be maintained unobstructed. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the above listed observations and stated the city did not require the back door to be an exit. LALD/CNS-A stated the the exiting plan would be revised to remove the back door as an exit. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800			

Minnesota Department of Health

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0 800	Continued From page 16 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 15, 2025, at 12:20 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed the following: - In the basement bedrooms, storage room, and living room: Adhesive had oozed out between the laminate floor tiles, creating a sticky floor surface. The spaces between the floor tiles were soiled. Base trim and lower wall surfaces were soiled and	0 800			

Minnesota Department of Health

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0 800	Continued From page 17 water stained. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the above listed basement observations and stated water had leaked into the basement when the pump stopped working. LALD/CNS-A stated the pump had been fixed but the damaged surfaces had not yet been repaired. - Screen door hardware was installed and hanging loose from the top of the frame for the back door. During the facility tour interview on May 15, 2025, LALD/CNS-A verified the above listed door observation and stated the screen door broke and had been removed as a result. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique 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.	0 810			

Minnesota Department of Health

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0 810	Continued From page 18 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 15, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to maintain an accurate FSEP evident by the following:	0 810			

Minnesota Department of Health

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0 810	Continued From page 19 On May 15, 2025, at 12:20 p.m., the surveyor toured the facility with LALD/CNS-A. During the facility tour, the surveyor observed the following: - The physical address for the facility was 1086 Highview Drive. The FSEP safety information listed an inaccurate physical address of 1096 Highview Drive. - A portable fire extinguisher was installed in the basement laundry room. The posted basement FSEP floor plans inaccurately identified that a portable fire extinguisher was installed in the basement hallway outside resident bedroom 5. - There was a storage room in the basement. The posted basement FSEP floor plans inaccurately labeled this storage room as bedroom 6. - Resident bedrooms 4 and 5 were located in the basement. In the emergency preparedness manual binder, where the primary readily available copy of the FSEP was kept, the FSEP floor plan for the basement was not included. Record review of the available documentation indicated the licensee failed to develop a FSEP with procedures specific to the assisted living facility and the building occupants evident by the following: - The FSEP was a template from a third party provider and included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP inaccurately directed the building occupants to pull the nearest fire alarm. Pull fire alarms were not installed at this facility. - The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection	0 810			

Minnesota Department of Health

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0 810	Continued From page 20 procedures necessary for residents were included. - The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency evident by a lack of these procedures in the plan. During an interview on May 15, 2025, at 2:00 p.m., LALD/CNS-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire evident by the lack of documentation to support this training had been completed. No FSEP training records were provided. During an interview on May 15, 2025, at 2:00 p.m., LALD/CNS-A stated employees were trained at the time of hire on the FSEP, but these trainings had not been documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to	0 900			

Minnesota Department of Health

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0 900	Continued From page 21 the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care (OOLTC) a complete unsigned copy of its contract. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 12, 2025, at 1:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she did not submit a blank	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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0 900	Continued From page 22 contract to OOLTC as she was unaware of the requirement. The surveyor provided them with the licensee's regional ombudsman's electronic mail (e-mail) address. On May 15, 2025, at 1:42 p.m., via e-mail, the facility's regional ombudsman indicated they did not receive a blank contract for this facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 970			

Minnesota Department of Health

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0 970	Continued From page 23 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: R1 and R2 were admitted for assisted living services on January 19, 2025, and January 13, 2025, respectively. R1 and R2's [Licensee's] Assisted Living Contract signed January 19, 2025, and January 13, 2025, respectively, on page 12, under Miscellaneous Provisions 1. Responsibilities, included the following statement, "The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that resident shall be responsible for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the residentunless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents." On May 12, 2025, at 3:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the contract used for R1 and R2 was the current contract for all residents. When pointing out the waiver of liability, LALD/CNS-A explained their consultant stated they would be held liable if it was only due to their negligence. LALD/CNS-A explained she would create an addendum to remove the waiver of liability. The licensee's Notifications policy effective December 11, 2024, indicated prior to providing	0 970			

Minnesota Department of Health

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0 970	Continued From page 24 housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01530 SS=D	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	01530			

Minnesota Department of Health

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01530	Continued From page 25 the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees had completed at least eight (8) hours of initial dementia training for supervisors of direct care staff within 120 working hours of the employment start date for one of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 12, through May 14, 2025, throughout the survey, the surveyor observed LALD/CNS-A	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01530	Continued From page 26 provide nursing supervision to the licensee's residents and unlicensed personnel (ULP)-B. LALD/CNS-A began employment (when first resident moved in under facility's provisional assisted living licensure) on January 13, 2025. On May 12, 2025, at 1:10 p.m., LALD/CNS-A explained she worked about three days per week during the day performing nursing tasks then also worked all overnight shifts (Monday through Sunday from 8:00 p.m. to 8:00 a.m. each week). LALD/CNS-A's employee record included 5.5 hours of dementia training completed, of training portability within 18 months of LALD/CNS-A's hire date with the licensee, missing 2.5 hours of the required eight hours within 120 hours of employment start date for supervisors of direct care staff. On May 13, 2025, at 9:30 a.m., LALD/CNS-A thought since the facility was not licensed as dementia care, the eight (8) hours was not required. She stated she completed the dementia training through her other job. After reviewing the statute requirement, she verbalized understanding. The licensee's Dementia Education policy effective December 11, 2024, included supervisors of direct care staff must have at least eight (8) hours of initial training within 120 working hours of employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER JACOB SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 HIGHVIEW DRIVE NEW BRIGHTON, MN 55112			
(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
01560	Continued From page 27	01560			
01560 SS=C	144G.64 (a; 5), (b) Training in Dementia, Mental Illness, and De- (5) new staff members may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required dementia, mental illness, and de-escalation training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; (5) person-centered planning and service delivery; (6) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (7) de-escalation techniques and communication; and (8) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include the required content.	01560			

Minnesota Department of Health

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01560	Continued From page 28 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under a provisional assisted living license. The licensee lacked a written or electronic description form of their training program, the categories of employees trained, the frequency of training, and the basic topics covered. On May 13, 2025, at 1:46 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was unaware of the requirement and was shown where to find the requirement on their policy. The licensee's Notifications policy effective December 11, 2024, indicated information regarding the training program for services to residents with dementia would be available to residents, families and others who requested it. The policy also indicated the above required content would be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			

Minnesota Department of Health

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01620	Continued From page 29	01620			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) assessed one of two residents (R2) during a change in the needs of the resident related to mobility, diet, and pain. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620			

Minnesota Department of Health

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01620	Continued From page 30 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on May 12, 2025, at 10:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated when a change in condition assessment was completed, the online electronic health record (EHR) would populate the most recent nursing assessment then LALD/CNS-A would make changes to the assessment based on the resident's change. R1 had diagnoses of cerebral vascular accident (stroke), spinal osteochondrosis (degenerative changes in the intervertebral discs of the spine), and frequent loose stools alternating with constipation. R1's medical record lacked a change in condition assessment to assess R1's diet, mobility, and pain. R1's Assessment by Date (nursing assessment) dated February 20, 2025, indicated "I have reviewed each question and determined all assessment items are up-to-date and accurate," at the top of the assessment completed by LALD/CNS-A. R1 reported no pain and required assistance with the following based on the nursing assessment: -applying compression socks; -ambulation using walker, transfers, and wheeling using wheelchair; and -mechanical soft diet (soft foods, cooked	01620			

Minnesota Department of Health

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01620	Continued From page 31 vegetables, ground meats, avoiding hard, crunchy or tough foods). R1's provider progress note and orders dated April 14, 2025, indicated R1's chief complaint was bilateral (both) knee pain and swelling. R1 had been experiencing increased pain on the left knee for the past 3-4 weeks. R1 was provided oxycodone 5 milligrams (mg) at a different clinic. R1 currently ambulated with a walker after a stroke in 2019 and experienced increased weakness and neuropathy (nerve pain) post stroke. R1 was prescribed naproxen 500 mg tablet with food twice daily as needed for pain and inflammation. Provider also ordered a knee brace. R1's Med Admin Summary dated May 1-12, 2025, indicated R1 received the following medications related to pain: -gabapentin 300 mg capsule, one capsule three times daily; -acetaminophen (dose not indicated) tablet, one tablet every 8 hours as needed (PRN) for pain (no doses received); -naproxen 500 mg tablet, one tablet by mouth twice daily PRN (7 doses received for leg pain); - and -oxycodone 5 mg tablet, one tablet by mouth twice daily PRN for pain (6 doses received for leg pain). During interview on May 13, 2025, at 9:30 a.m., LALD/CNS-A stated R1 had mechanical soft diet listed in his medical record, but R1 was currently on a regular diet. The mechanical soft diet was temporary and did not get changed in R1's record. During observation on May 13, 2025, at 10:15	01620			

Minnesota Department of Health

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01620	Continued From page 32 a.m., the surveyor observed unlicensed personnel (ULP)-B apply thigh length compression socks to R1. At 11:30 a.m., ULP-B administered one capsule of gabapentin 300 mg to R1. During observation and interview on May 14, 2025, at 10:00 a.m., the surveyor observed R1 completing his fried eggs and toast for breakfast. R1 stated he had a stroke and used his wheelchair years ago but worked his way up to using a cane but recently started having knee/leg pain and was waiting to receive his first steroid injection in the knee. In the meantime, he had been using his four-wheeled walker (4WW). During interview on May 14, 2025, at 10:14 a.m., ULP-B stated R1 did not use his wheelchair, but had it when she first met him. ULP-B stated there were times when he used it as a chair when his legs became swollen but otherwise, he used his cane then the 4WW since his recent decline. During interview on May 13, 2025, at 1:35 p.m., LALD/CNS-A stated when completing quarterly (90-day) assessments, she reviewed the prior assessment and made changes based on what was observed. The licensee's Assessment and Reassessment policy effective December 11, 2024, indicated ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident. The licensee's Comprehensive Nursing Assessment policy effective December 11, 2024, indicated the registered nurse would conduct a comprehensive assessment utilizing a uniform assessment tool that includes the following:	01620			

Minnesota Department of Health

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01620	Continued From page 33 -activities of daily living; -diet; and -pain including location, frequency, intensity, duration, and effectiveness of medications and nonmedication interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640			

Minnesota Department of Health

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01640	Continued From page 34 Based on observation, interview, and record review, the licensee failed to ensure a service plan had been signed or authenticated by the facility representative and by the resident, or the resident's representative, to document agreement on revision of services to be provided, for one of one resident (R2) receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on May 12, 2025, at 10:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had provided blood glucose monitoring in the past but it was discontinued. R2 had diagnoses of diabetes mellitus type II, high cholesterol, and opioid abuse. R2's Exhibit 2: Service Plan signed January 13, 2025, indicated the facility provided blood glucose checks three times daily and insulin administration. R2's Master Care Plan dated May 13, 2025, indicated R2 received assistance with medication management, applying/removing compression socks, laundry, housekeeping, meals, and behavior management.	01640			

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01640	Continued From page 35 R2's signed provider orders dated May 7, 2025, stopped blood glucose checks altogether, and the order did not have insulin as a current medication. R2's medical records lacked a revised service plan with a signature or other authentication by the facility and by the resident or their representative, documenting agreement on the services to be provided. During observation on May 13, 2025, at 10:00 a.m. and 11:05 a.m., unlicensed personnel (ULP)-B administered medications to R2. During interview on May 14, 2025, at 1:23 p.m., LALD/CNS-A stated when she updated the service task on the electronic health record (Residex), she discussed the changes with R2 but did not have a new service agreement signed. No further information was 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, the assisted living facility 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	01730			

Minnesota Department of Health

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01730	Continued From page 36 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be 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 (R1, R2). This practice resulted in a level two violation (a	01730			

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01730	Continued From page 37 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: R1 R1 had diagnoses of cerebral vascular accident (stroke), spinal osteochondrosis (degenerative changes in the intervertebral discs of the spine), and frequent loose stools alternating with constipation. During observation on May 13, 2025, at 11:30 a.m., unlicensed personnel (ULP)-B administered gabapentin 300 mg, one capsule to R1 for nerve pain. R1's Exhibit 2: Service Plan signed January 19, 2025, indicated R1 received medication administration and management. R1's medical record included a medication management plan that read who was responsible for monitoring medication supplies and reordering. R1's medication management plan lacked the following required content: -identification of medication management tasks that would be delegated to unlicensed personnel (ULP); -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730			

Minnesota Department of Health

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01730	Continued From page 38 -documentation of specific resident instructions relating to the administration of medications; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R2 R2 had diagnoses of diabetes mellitus type II, high cholesterol, and opioid abuse. During observation on May 13, 2025, at 10:00 a.m., ULP-B grabbed one small plastic bottle of methadone liquid (helps ease withdrawal symptoms from opioid addiction) with pharmacy label indicating 10 milligrams (mg)/milliliters (ml), give 20 mg. ULP-B poured water into the bottle to dilute the liquid and R2 took the medication in one gulp. ULP-B then charted the administration on R2's electronic medication administration record (eMAR). R2's Master Care Plan dated May 13, 2025, indicated R2 received assistance with medication administration and management. The care plan also indicated R2 required storing insulin in the refrigerator. R2's After Visit Summary (AVS) signed May 7, 2025, read R2's insulin pens were discontinued and did not include any type of insulin to be administered. R2's individualized medication management plan (IMMP) last updated May 13, 2025, still indicated R2 required storage of insulin. R2's Med Admin Summary-Month (eMAR) for May 2025, indicated R2 took the following medication:	01730			

Minnesota Department of Health

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01730	Continued From page 39 -methadone 20 ng [sic] of methadone by mouth daily at 10:00 a.m. (lacked instruction telling ULPs to mix water or other liquid with the medication). R2's record lacked a prescriber order for methadone and instructions for use. Methadone (by mouth) under "Learn More" retrieved from Allina Health website last reviewed on July 4, 2018, read to mix oral liquid with two (2) tablespoons of liquid. Drink the medicine right away. On May 13, 2025, at 1:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated when completing a quarterly nursing assessment, the electronic health record populates the most recent assessment completed and she went through the assessment and made changes based on observations. She stated not updating the medication management plan was an oversight. The licensee's undated Medication Management Program policy indicated the registered nurse would complete a face-to-face nursing assessment that included storage/security of medications, and medication reconciliation to include a change in condition that contraindicated continued administration of the medication. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication	01760			

Minnesota Department of Health

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01760	Continued From page 40 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to verify accuracy of prescriber orders when transcribing orders for two of two residents (R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on May 12, 2025, at 10:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management to all current residents.	01760			

Minnesota Department of Health

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01760	Continued From page 41 R2 During observation on May 13, 2025, at 10:00 a.m., unlicensed personnel (ULP)-B administered methadone 20 milligram (mg) to R2 for opioid addiction, then observed each resident had weekly medication boxes in each plastic bin that included the original bottles of medications dispensed by the pharmacy. At 11:05 a.m., ULP-B administered one capsule of gabapentin 300 mg to R2 for pain. R2 had diagnoses of diabetes mellitus type II, high cholesterol, and opioid abuse. R2's Master Care Plan dated May 13, 2025, indicated R2 received assistance with medication administration and management. R2's After Visit Summary (AVS) signed on April 17, 2025, ordered the following: -lithium carbonate 150 mg capsule, one capsule by mouth (PO) at bedtime to stabilize mood; -gabapentin 300 mg capsule, one capsule PO three times a day; and -Lidocaine 1% ointment, apply to skin 1 application twice daily PRN on chest wall for pain. R2's AVS signed on May 7, 2025, ordered the following: -discontinue lidocaine 5% ointment; -acetaminophen 325 mg tablet, 3 tablets PO three times daily PRN for pain (changed from 2 to 3 tablets and frequency changed) -atorvastatin 40 mg tablet, one tablet PO at bedtime for high cholesterol; -Eliquis 5 mg tablet, one tablet PO twice daily for atrial fibrillation (irregular heartbeat); -furosemide 20 mg tablet, one tablet PO daily for fluid retention;	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01760	Continued From page 42 -gabapentin 300 mg capsule, 1-2 capsules PO three times daily PRN (changed from scheduled to PRN, and dose changed; -tamsulosin 0.4 mg capsule, one capsule PO daily 30 minutes after same meal each day for urinary flow; -melatonin 3 mg tablet, one tablet PO at bedtime PRN for sleep; -Tums 500 mg tablet, one tablet by mouth twice daily PRN for upset stomach; and -Ventolin 108 micrograms (mcg) inhaler, inhale 2 puffs every 4 hours PRN for wheezing. R2's Med Admin Summary-Month (medication administration record) for May 2025, indicated the following transcription errors: -lacked lithium 150 mg, one capsule daily at bedtime; -Eliquis 5, did not indicate "mg" as ordered; -furosemide 20, did not indicate "mg" as ordered; -gabapentin 300, did not indicate "mg" as ordered and was transcribed as tablet, not capsule; -atorvastatin 40, did not indicate "mg" as ordered; -tamsulosin, no strength listed; -acetaminophen, no strength listed, read 2 tablets every 6 hours, but order read 3 tablets three times per day PRN; -lidocaine was still listed when discontinued on May 7, 2025; -melatonin, no strength listed, one tablet by mouth for insomnia (no frequency listed or whether scheduled or PRN); and -Ventolin, no strength listed, one puff (order read two puffs) every 4 hours PRN. R1 During observation on May 13, 2025, at 11:30 a.m., ULP-B administered gabapentin 300 mg, one capsule to R1.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01760	Continued From page 43 R1 had diagnoses of cerebral vascular accident (stroke), spinal osteochondrosis (degenerative changes in the intervertebral discs of the spine), and frequent loose stools alternating with constipation. R1's Exhibit 2: Service Plan signed January 19, 2025, indicated R1 received medication administration and management. R1's provider progress note and order signed April 14, 2025, read: -start naproxen 500 mg tablet, one tablet with food or milk twice a day PRN for pain; -tamsulosin 0.4 mg capsule, one capsule PO daily; and -Tums 200 mg, calcium 500mg tablet, two tablets PO every 4 hours PRN, do not take more than 10 tablets daily. R1's Med Admin Summary-Month dated May 2025, read: -tamsulosin 0.4 mg, BPH (benign prostatic hyperplasia), no route or frequency; -acetaminophen (no strength), take one tablet PO every 8 hours PRN (no indication); -naproxen 500, did not indicate "mg" as ordered, one tablet PO with food or milk twice daily PRN for pain (7 doses administered between May 4-11); -Tums (no strength), two tablets PO every 4 hours PRN for heartburn, do not exceed 10 tablets daily. During interview on May 13, 2025, at 12:08 p.m., LALD/CNS-A stated she accompanied R1 at his most recent appointment and the provider instructed R1 to take one capsule of gabapentin scheduled three times a day, then one capsule three times per day as needed. She stated she	01760			

Minnesota Department of Health

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01760	Continued From page 44 read the AVS wrong but had been setting up one capsule three times per day scheduled in the weekly medication box. At 1:22 p.m., while going over R1 and R2's medication administration records (MAR), LALD/CNS-A stated direction for use was missing on the tamsulosin, and the strength was missing for multiple medications. She stated she was responsible for transcribing the medications and manually entered them onto the electronic health record (Residex). The licensee's Prescriber's Orders policy effective December 11, 2024, read the registered nurse was responsible for implementing medication and treatment orders. The licensee's Assessment of Medications policy effective December 11, 2024, read medication reconciliation identified the most accurate list of all medications the resident was taking, including the name, dosage, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber of other provider. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=D	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.	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01770	Continued From page 45 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for one of two residents (R2) who received medication setup services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on May 12, 2025, at 10:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to all residents which included weekly medication set up. R2 was admitted for services on January 13, 2025, and had diagnoses including diabetes mellitus type II, high cholesterol, and opioid abuse. R2's Exhibit 2: Service Plan signed January 13, 2025, indicated R2 received weekly medication set up by the nurse and daily medication administration. R2's After Visit Summary (AVS) signed on April 17, 2025, ordered the following: -lithium carbonate 150 mg capsule, one capsule	01770			

Minnesota Department of Health

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01770	Continued From page 46 by mouth (PO) at bedtime to stabilize mood; and -gabapentin 300 mg capsule, one capsule PO three times a day, R2's AVS signed on May 7, 2025, ordered the following: -gabapentin 300 mg capsule, 1-2 capsules PO three times daily PRN (as needed) (changed from scheduled to PRN, and dose changed). R2's Med Admin Summary-Month dated May 2025, indicated the following instruction for the above order: -gabapentin 300 (strength was missing), one to two tablet [capsule] by mouth three times a day (8:00 a.m., 12:00 p.m., and 8:00 p.m.); and -lacked lithium instruction. R2's record lacked documentation of medication set up number of capsules of gabapentin and documentation of setting up lithium. During observation on May 13, 2025, at 11:05 a.m., unlicensed personnel (ULP)-B pulled out a mediplanner that contained medications for one week and poured one capsule of gabapentin from the Tuesday slot into a medication cup and administered it to R2. During documentation on the electronic medication administration record (eMAR), instructions indicated give one-two tablet [sic] by mouth three times a day. ULP-B stated if the resident requested two capsules of gabapentin, she would contact the registered nurse before giving it to R2. During interview on May 13, 2025, at 12:08 p.m., LALD/CNS-A stated she went with R2 to his provider appointment and the provider instructed R2 to take one capsule scheduled three times a day, then have one capsule three times per day	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01770	Continued From page 47 PRN. The PRN was added to the previous scheduled dose. LALD/CNS-A stated she had been setting up one capsule of gabapentin in the weekly mediplanner and the PRN supply was available in its original pharmacy bottle within the medication cabinet if needed. During interview on May 14, 2025, at 1:23 p.m., the surveyor asked LALD/CNS-A if R2 was supposed to be taking lithium, she stated yes and R2 recently started it. The surveyor asked to see the medication set up documentation. LALD/CNS-A provided a paper copy of R2's May eMAR (looked identical to the eMAR ULP used to document medication administration) that included written initials after each medication. LALD/CNS-A did not realize that lithium was not on the eMAR but confirmed she had been setting them up by pulling out the mediplanner and showing the gray capsule in the daily bedtime slot and grabbed the pharmacy bottle and showed the contents to the surveyor to compare. The pharmacy label indicated the medication was dispensed on April 17, 2025, and the bottle was nearly empty. The licensee's Medication Orders policy effective December 11, 2024, indicated the licensee would administer medications as prescribed and medication orders would be placed into the resident's clinical record. The licensee Clinical Records policy dated December 11, 2024, indicated the licensee would maintain documentation of services provided as identified in the service plan. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			

Minnesota Department of Health

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01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2) receiving medication administration. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During entrance conference on May 12, 2025, at 10:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated licensee provided medication management to all current residents. During observation on May 13, 2025, at 10:00 a.m., unlicensed personnel (ULP)-B grabbed one small plastic bottle of methadone liquid with pharmacy label indicating 10 milligrams (mg)/milliliters (ml), give 20 mg. ULP-B poured water into the bottle to dilute the liquid and R2 took the medication in one gulp. ULP-B then	01820			

Minnesota Department of Health

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01820	Continued From page 49 charted the administration on R2's electronic medication administration record (eMAR). R2 had diagnoses of diabetes mellitus type II, high cholesterol, and opioid abuse. R2's Master Care Plan dated May 13, 2025, indicated R2 received assistance with medication administration and management. R2's Med Admin Summary-Month (eMAR) for May 2025, indicated R2 took the following medication: -methadone 20 ng [sic] of methadone by mouth daily at 10:00 a.m. R2's medical record included a "Chain of Custody Record" dated May 1, 2025, indicating the addiction program provided R2 and ULP-B 20 doses of methadone to last through May 21, 2025. The receipt did not include prescriber orders or details on how to take the medication. R2's medical record lacked a prescriber or chart order to include strength, dosage, frequency, and route of administration for methadone. During interview on May 13, 2025, at 12:36 p.m., LALD/CNS-A stated she did not have an order for R2's methadone. The clinic dispensed the methadone, not R2's pharmacy, so she did not think anything beyond a clinic visit was needed. LALD/CNS-A stated R2 had been on this program for a period of time and was almost done. The licensee's Medication Orders policy effective December 11, 2024, indicated licensee would maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01820	Continued From page 50 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document correctly and failed to document why treatments or therapies were not provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01960	Continued From page 51 The findings include: INCORRECT DOCUMENTATION R1 had diagnoses of cerebral vascular accident (stroke), spinal osteochondrosis (degenerative changes in the intervertebral discs of the spine), and frequent loose stools alternating with constipation. R1's Master Care Plan last updated on February 20, 2025, indicated R1 received medication administration and management, assistance with compression socks, dressing, bathing, and behavior management. During observation on May 13, 2025, at 10:15 a.m., unlicensed personnel (ULP)-B assisted R1 by applying Vaseline to R1's legs (had just showered) then applied thigh length black compression socks to both legs. R1's prescriber order dated February 13, 2025, ordered medical compression stockings (elastic & supports), use 2-3 hours a day when walking or standing. R1's Service Recap Summary-Month dated May 1-14, 2025, indicated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A initialed 13 out of 14 days indicating compression stockings applied in the morning (AM). On May 6, 2025, ULP-B initialed compression sock completion. On May 13, 2025, LALD/CNS-A initialed under AM compression stocking service, when ULP-B was observed completing the task. During interview on May 14, 2025, at 10:14 a.m., ULP-B stated she worked Monday through Friday	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01960	Continued From page 52 from 8:00 a.m. to 8:00 p.m., and weekends occasionally. She was trained how to use the electronic health care program (Residex) and had her own log in profile. ULP-B was not sure why LALD/CNS-A charted services completed including the compression socks, but felt maybe LALD/CNS-A wanted it charted right away because the surveyor was there. During interview on May 14, 2025, at 1:23 p.m., LALD/CNS-A stated she had been charting for ULP-B when she should not have for R1's services. LACKED DOCUMENTATION OF REFUSAL R2 had diagnoses of diabetes mellitus type II, high cholesterol, and opioid abuse. R2's Master Care Plan last updated on May 13, 2025, indicated R2 received assistance with medication administration and management, behavior management, bathing, dressing/grooming, meals, and compression socks. R2's prescriber order dated December 31, 2024, ordered compression socks daily for 8 hours a day due to lower extremity swelling. R2's Service Recap Summary-Month dated May 1-12, 2025, included staff initials daily under compression stockings in the AM. R2's record lacked documentation of compression sock refusals. During interview on May 13, 2025, at 11:18 a.m., LALD/CNS-A stated R2 did not wear his compression socks anymore. She said his	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01960	Continued From page 53 medical provider was already aware of it. LALD/CNS-A stated her documentation (initials) on the service recap summary was documentation of it being offered, but she agreed it should have been documented as declined and stating the reason why. LALD/CNS-A asked the surveyor if the service should be put on hold. The surveyor observed R2's compression sock service put on hold after this conversation. During interview on May 14, 2025, at 12:30 p.m., ULP-B stated R2 sometimes wore compression socks, but did not like wearing them. R2 did not have compression socks on today per ULP-B. ULP-B stated she would click the "declined/refused" button on the electronic health record and document why R2 refused. ULP-B was unsure why the surveyor was unable to locate that documentation. During interview on May 14, 2025, at 1:23 p.m., LALD/CNS-A stated for documentation of "declined/refused," it just showed up as "addressed" (by staff initials), but did not show red circles around the initials which indicate declined or refused. The licensee's Treatment and Therapy Management policy effective December 11, 2024, indicated each staff member who administers a treatment or therapy was responsible for documenting in the clinical record. The policy also indicated when a treatment or therapy was not administered as ordered or prescribed, the staff would document the reason why it was not administered and any follow-up procedures provided to meet the resident's needs as documented in the care plan or treatment plan or as ordered by the authorized prescriber.	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
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01960	Continued From page 54 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity potentially, affecting all residents, staff, and visitors. 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). The findings include: On May 12, 2025, at 1:32 p.m., the surveyor could not locate signage with the required	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40687	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER JACOB SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 HIGHVIEW DRIVE NEW BRIGHTON, MN 55112			
(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
03090	Continued From page 55 electronic monitoring content posted at the facility's entrance. The surveyor asked licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A where the notice could be found, and she stated they did not have one because they did not have cameras on site. The licensee's Electronic Monitoring policy dated December 11, 2024, noted licensee would post a sign at each facility entrance accessible to visitors that stated: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090			



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

Jacob Services LLC
1086 Highview Drive
New Brighton, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 40687

Risk:
License:
Expires on:
CFPM: NAFIISA DAHIR
CFPM #: CFPM-55687; Exp:
01/27/2028

Inspection Info

Report Number: F1005251020
Inspection Type: Full - Single
Date: 5/13/2025 Time: 10:10:19 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION COMPLETED WITH HOUSE MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR ANNA BOHNEN.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

THERMOLABELS WERE ON SITE AND MANAGER SENT INSPECTOR A PICTURE AFTER THE INSPECTION, SHOWING THAT THE THERMOLABEL RUN THROUGH THE DISHWASHER REACHED AT LEAST 180 DEGREES F.

FLOORING IS LAMINATE AND CABINETS ARE WOOD WITH HOLLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005251020 from 5/13/2025

NAFIISA DAHIR

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us



Metro District Office
Minnesota Department of Health
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St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Jacob Services LLC
New Brighton
County/Group: Ramsey County

Inspection Info

Report Number: F1005251020
Inspection Type: Full
Date: 5/13/2025
Time: 10:10:19 AM

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

Location: KITCHEN REFRIGERATOR at 39 Degrees F.

Comment:

Violation Issued?: No

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

Location: KITCHEN REFRIGERATOR at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MASHED POTATOES; **Temperature Process:** Cold-Holding

Location: KITCHEN REFRIGERATOR at 40 Degrees F.

Comment:

Violation Issued?: No



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St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Jacob Services LLC
New Brighton
County/Group: Ramsey County

Inspection Info

Report Number: F1005251020
Inspection Type: Full
Date: 5/13/2025
Time: 10:10:19 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: KITCHEN DISHWASHER **Greater Than** 180 Degrees F.
Comment: AT LEAST 180 PER THERMOLABEL
Violation Issued?: No