



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

March 10, 2026

Licensee
The Hummingbird
7704 Cole Ave
Meadowlands, MN 55765

RE: Conditional License Number 419661
Health Facility Identification Number (HFID) 30728
Project Number(s) SL30728016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 24, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, Subd. 1 (a), MDH is issuing a 90-day conditional license, pending appeal.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

MDH may assess fines based on the level and scope of the orders outlined below; **however, no immediate fines are assessed for this survey of your facility.:**

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

St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions - \$1,000.00

St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

The total amount of **potential** fines that may be assessed related to these correction orders is \$5,500.00. **MDH is not imposing these fines against your license at this time.**

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue The Hummingbird a conditional assisted living facility license for 90 calendar days, pending appeal. At an unannounced point in time, within the 90 calendar days, MDH will conduct a

follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if The Hummingbird is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. No new admissions:** The Hummingbird will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. The Hummingbird must provide the Department:
 - i. A list of the names and birthdates of any individuals The Hummingbird is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- b. Consultant:** The Hummingbird will contract with an RN to provide consultation concerning all resident(s) to whom The Hummingbird provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from The Hummingbird. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with The Hummingbird and MDH must review the RN’s credentials and approve the selection. The Hummingbird is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to The Hummingbird in an effort to help The Hummingbird align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. The Hummingbird will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- c. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies The Hummingbird and the RN consultant about a change. Each report will be

electronically submitted to: **HRDConsultantReports.MDH@state.mn.us**. The content of the reports will include information such as:

- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- d. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of The Hummingbird to correct the violations cited during the follow-up (remove if not LOF) survey as well as to determine the overall practice of The Hummingbird in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- e. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.
- f. General Contractor:** The Hummingbird must provide the following to Supervisor Name (Supervisor Email Address) via email within 21-days of the date of this notice:
- i. Name
 - ii. License Number
 - iii. Contact Information

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if The Hummingbird is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If

MDH determines The Hummingbird is in substantial compliance on the follow up survey, MDH will remove the conditions from The Hummingbird's assisted living facility license, and The Hummingbird will correct any outstanding violations identified during the survey. If The Hummingbird is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit

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

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 Jessie Chenze directly at: 218-332-5175 or email at: Jessie.Chenze@state.mn.us.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

**Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division**

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER THE HUMMINGBIRD		STREET ADDRESS, CITY, STATE, ZIP CODE 7704 COLE AVE MEADOWLANDS, MN 55765			
(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 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: SL30728016-0 On November 18, 2025, through November 24, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 10 residents; 10 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on November 20, 2025, issued for SL30728016-0 tag identification 2310, at a scope and level of widespread, three (I). An immediate correction order was identified on November 21, 2025, issued for SL30728016-0 tag identification 1760, at a scope and level of isolated, four (J). An immediate correction order was identified on November 21, 2025, issued for SL30728016-0 tag identification 1640, at a scope and level of	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.		

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 pattern, three (G). During the survey, the licensee took action to mitigate the immediate risks, however, noncompliance remained, and the scope and level remain unchanged	0 000			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470			

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0 470	Continued From page 2 by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice a year. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living dementia care license for a capacity of 13 residents and had a current census of 10 residents. During the entrance conference on November 18, 2025, at 10:25 a.m. through 11:36 a.m., assisted living director in residency (ALDIR)-A stated he recently became aware the licensee was required to have a staffing plan that was revised twice a year and had not developed a written staffing plan to determine staffing hours based on resident care needs. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated June 13, 2024, indicated the licensee would implement a written staffing plan that would be evaluated at a minimum of two times per year.	0 470			

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 4 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 480			

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0 480	Continued From page 5 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to update and post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors.	0 550			

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0 550	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on November 18, 2025, at 11:42 a.m., the surveyor observed and confirmed with assistant living director in residency (ALDIR)-A, the licensee's grievance procedure was posted at the main entrance within the facility; however, lacked the updated contact information of the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent	0 580			

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0 580	Continued From page 7 services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 10 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 the residents). The findings include: During entrance conference on November 18, 2025, at 10:25 a.m. through 11:36 a.m., assisted living in residency (ALDIR)-A stated the licensee had not had any organized any quality manage meetings or minutes of meetings since became licensed in February 2025. The licensee's Quality Management Plan policy dated May 1, 2025, indicated the Assisted Living Director would develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with current professional standards and the highest quality	0 580			

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0 580	Continued From page 8 services for residents. All staff will be involved in the implementation of performance improvement efforts. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined	0 620			

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0 620	Continued From page 9 in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R4) who eloped from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/24/2025
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0 620	Continued From page 10 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held a current assisted living dementia care license with a current census of 10 residents. During entrance conference on November 18, 2025, at 10:25 a.m., assistant living director in residency (ALDIR)-A stated the licensee had not filed any MAARC reports since change of ownership effective February 1, 2025. ALDIR-A stated they had one resident elopement back in June 2025 and had not filed a MAARC report. ALDIR-A stated R4 had eloped from the facility, the sheriff was called and R4 was found in the woods with the use of a drone. ALDIR-A stated he was not aware a MAARC report needed to be filed since R4 had been located. R4's diagnoses included severe Alzheimer's dementia of other onset with mood disturbance, hypertension (HTN- high blood pressure), and hallucination. R4's Clinical Update Summary (90-day review) dated February 20, 2025, indicated R4 was at risk for leaving the property to walk R4 believed to be familiar and within walking distance. Example "he is going fishing, he is going to the bar, he is going home, he is going to check on a friend", however, R4 had no knowledge of how to get there. R4 did not let staff know he was going out and would just	0 620			

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0 620	Continued From page 11 leave and staff would go out after R4 and was easily redirected back to the facility. R4's boots and shoes were kept locked in the pantry so R4 would have to ask staff for footwear before leaving. Staff were to watch R4 the entire time R4 was outside. In addition, R4's mother stated R4 would walk to the bar from her house, and she would call the bar and tell them to send R4 back home, and he would come back. R4's Assessment dated May 15, 2025, indicated R4's risk of elopement/wandering had the same information documented from R4's Clinical Update Summary dated February 20, 2025, as noted above, with the addition of R4 was pretty redirectable, accustomed to the area and knew his way around. In addition, R4's assessment indicated R4 was at risk to be abused due to confusion, however, no measures were specified to reduce the risk for abuse. R4 was potentially getting alert-a-patch due to elopement pending family consent and setting up the appliance. Patch was to be on for 10 days to back, then replaced. The licensee had have the appliance; however, was not on resident at this time, pending family consent and the plan was for future due to weather improving and resident enjoyed walking outside. R4's Resident Notes dated May 1, 2025, to July 1, 2025, included the following entry written by unlicensed personnel (ULP)-F: -On June 14, 2025, at 9:45 p.m., ULP-F documented at 8:00 p.m., R4 was in his room. Later that night, (time not documented) staff went to check on R4 in his room and R4 was gone. Staff checked rooms in main building and the grounds outside of the building calling R4's name several times. One staff went looking all around town, driving down trails and roads and was	0 620			

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0 620	Continued From page 12 unable to find R4. Staff called and informed ALDIR-A and owner (H), both came in and drove around several times, then decided to call the Sheriff. The Sheriff and search team searched the trails behind the building and found R4 in the woods in a small camp like setting with the use of a Drone. R4's resident record lacked evidence an incident report or MAARC reported had been completed. The licensee's Missing Resident policy dated May 1, 2025, noted when a resident who meets the criteria in rule, cannot be located and is not where they can reasonably be expected to be staff promptly implements the missing resident procedure. After the missing resident was located, a staff member would immediately notify local law enforcement, the resident's representatives, and the resident's case manager, if applicable. An Incident report would be completed and notification to the Common Entry Point (CEP) e.g.; MAARC, if appropriate. If elopement occurred, the registered nurse (RN) would complete an assessment including approaches to decrease risk of elopement in the future; and would appropriately update any other necessary documentation such as service plans, individual abuse prevention plans ect. The licensee's Vulnerable Adult Maltreatment Policy dated May 1, 2025, indicated all staff would be educated on reporting requirements under the MN Vulnerable Adults reporting Act (VAA) during education and as part of annual education. During new employee orientation for assisted living staff and at least annually during employee in-services, the RN would review the VAA reporting requirements [and, if applicable, the requirements related to maltreatment of minors],	0 620			

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0 620	Continued From page 13 our internal reporting and investigation process and our internal policy that mandates that any staff or other persons reporting witnessed or suspected maltreatment in good faith will be protected from any retaliatory measures by our organization. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 620			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680			

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0 680	Continued From page 14 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and post an emergency preparedness plan prominently with all the required content. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on November 18, 2025, at 11:42 a.m., with assisted living director in residency (ALDIR)-A, the surveyor did not observe the licensee's Emergency Preparedness Plan (EPP) in the common areas of the facility or a sign indicating the location of the EPP. ALDIR-A stated the EP binder was currently at his house being worked on and was usually located in the nurses office, which was locked when the nurse was not in office. The licensee's undated Disaster Planning and Emergency Preparedness Plan indicated the Emergency Disaster Plan was located in the nurses room and respectfully lacked the following: -hazardous vulnerability assessment; -documentation of a quarterly review of missing	0 680			

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0 680	Continued From page 15 resident policy; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - subsistence needs for staff and residents during emergency situation; - procedure for tracking staff and residents; - arrangements with other facilities/providers to receive residents; - a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy - a method of sharing information from the emergency plan with residents and their families - an emergency prep testing requirements to include: - participation in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise; and - an additional annual exercise that may include a second full-scale exercise or mock disaster drill or table-top exercise and analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. - lacked agreements - VA Assessment - description of resident population	0 680			

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0 680	Continued From page 16 - quarterly missing resident policy On November 24, 2025, at 2:30 p.m., ALDIR-A stated the licensee's EPP had not been fully developed by the previous owners and ALDIR-A was in the process of learning the required content and completing the licensee's EPP. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the licensed assisted living director (LALD) and clinical nurse supervisor (CNS) must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. The licensee's undated Disaster Planning and Emergency Preparedness Plan indicated the Disaster planning and emergency preparedness plan indicated the licensee must meet the following requirements: -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;	0 680			

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0 680	Continued From page 17 -post an emergency disaster plan prominently; -provide building emergency exit diagrams to all residents; -post emergency exit diagrams on each floor; -have a written Policy and procedure for missing tenant residents; -provide emergency and disaster 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 the site; and -meet any additional requirements adopted in the rule. 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 and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 775			

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0 775	Continued From page 18 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 19, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780			

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0 780	Continued From page 19 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 19, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			

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0 790	Continued From page 20	0 790			
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 19, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 790			

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0 790	Continued From page 21 days	0 790			
0 800 SS=A	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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 19, 2025, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800			

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0 800	Continued From page 22	0 800			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
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 drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 19, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	01290			

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01290	Continued From page 24 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure background studies (BGS) were submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of three employees (unlicensed personnel (ULP)-C). This had the potential to affect all residents receiving services under the assisted living dementia care license. 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 November 18, 2025, at 10:25 through 11:36 a.m., assisted living director in residency (ALDIR)-A and clinical nurse supervisor (CNS)-B stated they were becoming familiar with the current minimum assisted living	01290			

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01290	Continued From page 25 requirements. ULP-C had an original hire date of July 21, 2014, and was rehired by the licensee on October 5, 2025 to provide direct care and services to the residents of the facility. The licenses weekly schedule dated November 17, 2025, through November 23, 2025, indicated ULP-C was scheduled to work the following shifts: -November 18, from 6:30 a.m. to 3:00 p.m.; -November 19, from 4:00 a.m. to 2:30 p.m.; and -November 22, and 23, from 2:30 p.m. to 10:30 p.m. ULP-C's employee record included a Department of Human Services Background Study Clearance letter dated August 6, 2021. On November 18, 2025, at 2:01 p.m., the surveyor reviewed the Department of Human Services (DHS) NetStudy employee roster against the licensee's current list of employees. ULP-C was listed on the employee roster; however, was not listed on the DHS NetStudy roster. At 2:02 p.m., CNS-B verified ULP-C was a current employee and was working that day providing care and services to the residents of the facility. On November 18, 2025, at 3:17 p.m., ALDIR-A stated ULP-C was originally hired July 21, 2014, through March 21, 2025, by the previous owners, and was rehired by the current owners on October 5, 2025. ALDIR-A stated ULP-C may not have had fingerprints redone when rehired for the BGS and that may be why ULP-C was not listed on the licensee's DHS NetStudy roster.	01290			

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01290	Continued From page 26 On November 19, at 12:17 p.m., ALDIR-A stated he had called the state and since ULP-C had not been reactivated within 180 days after ULP-C left, ALDIR-A had to pay a fee to run another BGS for ULP-C. The licensee's Background Checks dated May 1, 2025, indicated all employees, contractors, and regularly scheduled volunteers of the facility with direct resident contact would undergo a background study thorough DHS. Only those with satisfactory results would continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct	01470			

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01470	Continued From page 27 support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470			

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01470	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of three employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 November 18, 2025, at 10:25 a.m., owner (O)-H was identified as the responsible for assigning employee's Educare (web based training program). CNS-B was hired August 7, 2025, to supervise and provide direct care services to residents at the facility. Throughout the survey, CNS-B was observed providing care and services to the licensee's residents. CNS-B's employee record lacked documented evidence of the following required orientation: - overview of the Assisted Living statutes; - reporting maltreatment of vulnerable adults; - handling of resident complaints, reporting of	01470			

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01470	Continued From page 29 complaints, and where to report; - consumer advocacy services; - review of the types of Assisted Living services the employee would provide and the provider's scope of license; and - principles of person-centered planning and service delivery. On November 24, 2025, at 11:50 a.m., CNS-B stated employee training was assigned by O-H and would inform O-H to have assigned missing orientation training. The licensee's Assisted Living and Assisted Living with Memory Care Orientation-All Staff policy dated August 20, 2025, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. At a minimum, orientation must include the following topics: - an overview of Minnesota's assisted living law; - an introduction and review of agency policies and procedures related to provisions of assisted living services; - emergency and disaster training; - the assisted living bill or rights; - principles of person-centered planning and service delivery and how they apply to direct support services; - reporting maltreatment of vulnerable adults; - handling of resident complaints and reporting; and - consumer advocacy services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			

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01540	Continued From page 30	01540			
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the 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 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 one of three employees (unlicensed personnel (ULP)-C) received the required amount of mental illness and de-escalation training within the required time frame. 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	01540			

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01540	Continued From page 31 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 facility held an assisted living with dementia care license effective February 1, 2025, with an expiration date of January 1, 2026. During entrance conference on November 18, 2025, at 10:25 a.m. through 11:36 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was responsible for maintaining employee records. ULP-C was had an original hire date of July 21, 2014, through March 21, 2025, and was rehired on October 5, 2025, to provide direct care services to licensee's residents. On November 19, 2025, at 10:03 a.m., the surveyor observed ULP-C administering R2's medications. ULP-C's employee record lacked documented evidence ULP-C had completed two (2) hours of mental illness and de-escalation training by July 1, 2025. On November 24, 2025, at 12:40 p.m., CNS-B stated ULP-C had not completed any additional training since rehired by the licensee on October 5, 2025, to include required two (2) hours of mental illness and de-escalation training. The licensee's Assisted Living with Dementia Training policy dated August 20, 2025, indicated all employees of a licensed assisted living or a	01540			

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01540	Continued From page 32 licensed assisted living with dementia care who have not completed their initial dementia care training would not provide direct care independently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring	01620			

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01620	Continued From page 33 in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for one of one resident who had a change in condition (R3) and one of one resident (R4) with an elopement. 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	01620			

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01620	Continued From page 34 situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility held an assisted living with dementia care license effective February 1, 2025, with an expiration date of January 1, 2026. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated November 24, 2024, indicated the licensee had unlicensed staff in the building and available to respond to resident requests 24/7 and had a secured unit or building for wandering or exit-seeking behavior. During entrance conference on November 18, 2025, at 10:25 a.m., assisted living director in residency (ALDIR)-A stated the licensee was becoming familiar with current minimum assisted living requirements. Clinical nurse supervisor (CNS)-B stated resident assessments were completed upon admission, at day 14, every 90 days and with changes in conditions. R3 R3's diagnoses included history of cerebrovascular accident (CVA) with left sided weakness and was on palliative care (a specialized form of care that provides symptom relief, comfort and support to people living with serious or chronic illnesses). R3's Service Plan dated January 2, 2025, indicated R3 required assistance with dressing, grooming, bathing, toileting, transfers, bed mobility, medication administration, housekeeping and laundry.	01620			

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01620	Continued From page 35 R3's 90 Day Assessment dated September 9, 2025, indicated R3 required assist of one to two staff for bed mobility and transferred with a mechanical lift device with the assistance of two staff and received hospice services. R3's Resident Notes dated July 1, 2025, indicated the licensee's RN discussed with R3's prescriber in making a referral to hospice services to provide additional supportive services as R3's chronic wounds and condition as it continued to progress. R3's Resident Notes dated July 8, 2025, indicated R3 started on hospice services. R3's record lacked evidence a change of condition assessment was completed in July 2025, when R3 started hospice services. R4 R4 was admitted to the facility on October 10, 2024, and began receiving assisted living services from the licensee effective February 1, 2025. R4's diagnoses included severe Alzheimer's dementia of other onset with mood disturbance, hypertension (HTN- high blood pressure), and hallucination. R4's Service Plan (Waiver)- Addendum to Contract dated December 17, 2024, indicated R4's services included medication assist (assistance), behavior redirection and charting, safety checks, and assistance with bathing, grooming, dressing, and housekeeping. R4's Clinical Update Summary (90-day review) dated February 20, 2025, indicated R4 was at risk for leaving the property to walk somewhere that	01620			

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01620	Continued From page 36 he (R4) believes to be familiar and within walking distance. Example "he is going fishing, he is going to the bar, he is going home, he is going to check on a friend", however he (R4) has no knowledge of how to get somewhere or that where he is going is even tangible. He does not let staff know that he is going to leave; he just leaves, staff will go out after him, he has always been agreeable to turn back around. Currently boots and shoes are kept locked in the pantry so he must ask staff for footwear before he decides to leave. Staff to watch resident the entire time he is outside. In addition, R4's mother stated he would walk to the bar from her house, and she would call the bar and tell them to send him back home, and he would come back. R4's Assessment dated May 15, 2025, indicated R4's risk of elopement/wandering had the same information documented from R4's Clinical Update Summary dated February 20, 2025, as noted above, with the addition of R4 was pretty redirectable, and he was accustomed to this area and knows his way around this area. In addition, R4's assessment indicated R4 was at risk to be abused due to confusion, however, no measures were specified to reduce the risk for abuse. R4 was potentially getting alert-a-patch due to elopement pending family consent and setting up the appliance. Patch on for 10 days to back, then replace. Pending ok from family, we have the appliance, but not on resident at this time. Plan for future with weather improving and resident enjoys walking outside. During the course of the survey, the surveyor observed R4 exit the building several times independently to go outside to smoke. On November 18, 2025, at 9:35 a.m., the	01620			

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01620	Continued From page 37 surveyor entered the parking lot of the building and observed R4 outside on the walkway located near the main entrance of the building smoking with R6. On November 20, 2025, at 7:35 a.m., the surveyor observed R4 go outside to smoke with R6 without direct supervision. On November 20, 2025, at 3:28 p.m., the surveyor exited the building and observed R4 walking in the parking lot toward the entrance of the building smoking a cigarette. R4 appeared to be coming from the direction of the detached garage located next to the building. R4's Resident Notes- One Resident dated May 1, 2025, to July 1, 2025, included the following entries: -June 5, 2025, the previous RN indicated throughout the week, R4 had been fixated on finding a breathalyzer he needed to blow into before he was able to get a job. R4 had been pacing and wandering all throughout the hallways attempting to leave the building through the emergency exit doors. R4 had left the building and stayed around the facility and property. R4 would reference he was waiting for his dad to pick him up (who was deceased). R4 was noted to have hallucinations of rats and squirrels getting into places and swallowing his own teeth. -June 14, 2025, at 9:45 p.m., around 8:00 p.m., unlicensed personnel (ULP)-F indicated R4 had been in his room. Later that night, ULP-F went to check on R4 (no time indicated) and R4 was not his room. Staff checked rooms in the facility and grounds outside of the building calling out R4's name. One staff member drove around town and	01620			

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01620	Continued From page 38 near trails and was unable to find R4. Staff notified ALDIR-A and owner (O)-H, both came in and drove around town and were unable to find R4. The owners called the sheriff's office and reported R4 was missing. The sheriff and search team arrived and located R4 in a camp like setting in the woods with the use of a drone. R4's Service Recap Summary dated June 14, 2025, had the following entry written by ULP-F "Resident was in his room at 8:55 p.m., and was gone around 9:15 p.m., employees drove around all over, (owners names) drove all around until calling the cops. Sheriffs here with the drone and searching, found him." R4's Assessment dated June 26, 2025, and November 11, 2025 (138 days from previous assessment), respectively, indicated R4 was at risk for leaving the property to walk somewhere, R4 believed to be familiar and within walking distance. Example "he is going fishing, he is going to the bar, he is going home, he is going to check on a friend", however, R4 had no knowledge of how to get where he was going. R4 did not alert staff he was leaving and would just leave. R4 did not let staff know he was going out and would just leave. Staff would go out after R4 and R4 was easily redirected back to the facility. R4's boots and shoes were kept locked in the pantry so R4 would have to ask staff for footwear before leaving. Staff were to watch R4 the entire time R4 was outside. In addition, R4's mother stated R4 would walk to the bar from her house, and she would call the bar and tell them to send R4 back home, and he would come back. R4's Service Recap Summary for June 2025, July 2025, October 2025, and November 2025, respectively, lacked any safety checks on R4.	01620			

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01620	Continued From page 39 On November 20, 2025, at 2:00 p.m., CNS-B stated CNS-B provided the surveyor with all of R4's documentation CNS-B was able to find in R4's paper chart and electronic medical record. R4's medical record lacked a comprehensive reassessment or implementation of any new safety interventions following R4's elopement incident. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated May 1, 2025, indicated an RN would complete the following comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required: -Pre-Admission Assessment; -14-day assessment completed up to 14-days	01620			

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01620	Continued From page 40 after start of services; -Ongoing assessment: completed periodically but no less than every 90-days; and -Change in resident condition. The licensee's Missing Resident policy dated May 1, 2025, in indicated if an elopement occurred, the registered nurse would complete an assessment including approaches to decrease risk of elopement in the future; and would appropriately update any other necessary documentation such as service plans, individual abuse prevention plans ect. No further information was provided. TIME PERIOD FOR CORRECTION: Two-day (2) days	01620			
01640 SS=G	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	01640			

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01640	Continued From page 41 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all services identified in the service plan were implemented, for one of one resident (R4). The licensee failed to provide safety checks three times per day for R4. This resulted in an immediate correction order on November 21, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility held an assisted living with dementia care license effective February 1, 2025, with an expiration date of January 1, 2026. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) November 24, 2024, indicated security and monitoring services available were 15 minute, 30 minute, hourly, every two hours, and daily safety checks. During the entrance conference on November 18, 2025, at 10:25 a.m., assistant living director in	01640			

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01640	Continued From page 42 residency (ALDIR)-A stated the licensee was becoming familiar with the current minimum assisted living requirements. R4 was admitted to the facility on October 10, 2024, and began receiving assisted living services from the licensee effective February 1, 2025. R4's diagnoses included severe Alzheimer's dementia of other onset with mood disturbance, hypertension (HTN- high blood pressure), and hallucination. R4's Service Plan (Waiver)- Addendum to Contract dated December 17, 2024, indicated R4's services included safety checks three times daily. R4's Clinical Update Summary (90-day review) dated February 20, 2025, indicated R4 was at risk for leaving the property to walk somewhere that he (R4) believes to be familiar and within walking distance. Example "he is going fishing, he is going to the bar, he is going home, he is going to check on a friend", however he (R4) has no knowledge of how to get somewhere or that where he is going is even tangible. He does not let staff know that he is going to leave he just leaves, staff will go out after him, he has always been agreeable to turn back around. Currently boots and shoes are kept locked in the pantry so he must ask staff for footwear before he decides to leave. Staff to watch resident the entire time he is outside. In addition, R4's mother stated he would walk to the bar from her house, and she would call the bar and tell them to send him back home, and he would come back. R4's Assessment dated May 15, 2025, indicated	01640			

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01640	Continued From page 43 R4's risk of elopement/wandering had the same information documented from R4's Clinical Update Summary dated February 20, 2025, as noted above, with the addition of R4 was pretty redirectable, and he is accustomed to this area and knows his way around this area. In addition, R4's assessment indicated R4 was at risk to be abused due to confusion, however, no measures were specified to reduce the risk for abuse. R4 was potentially getting alert-a-patch d/t elopement pending family consent, and setting up the appliance. Patch on for 10 days to back, then replace. Pending ok from family, we have the appliance, but not on resident at this time. Plan for future with weather improving and resident enjoys walking outside. During the course of the survey, the surveyor observed R4 exit the building several times independently to go outside to smoke. On November 18, 2025, at 9:35 a.m., the surveyor entered the parking lot of the building and observed R4 outside on the walkway located near the main entrance of the building smoking with R6. On November 20, 2025, at 3:28 p.m., the surveyor exited the building and observed R4 walking in the parking lot toward the entrance of the building smoking a cigarette. R4 appeared to be coming from the direction of the detached garage located next to the building. R4's Resident Notes- One Resident dated May 1, 2025, to July 1, 2025, included the following entries written by unlicensed personnel (ULP)-F -June 14, 2025, at 9:45 p.m., ULP-F "at 8 pm (resident name) was in his room, staff went to put (2 person assist) to bed, Staff noticed (resident's	01640			

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01640	Continued From page 44 name) door open always, and room dark, went to check on him and he was gone, checked rooms in main bldg., and outside around bldgs, called him several times. 1 staff went looking all around town, driving down trails and roads, checking to no avail. Staff called and told Owners, couldn't get a hold of anyone close to help, owners came and drove around several times, then decided to call Sheriffs, they came did their thing and then owner took Sheriff out to the trail behind us, and he heard some talking, so more sheriffs arrived, used Drone and found him in the woods in a small camp like setting, supposedly crabbing. All is back to normal now.. Thank the Lord he was found and ok.." R4' s Service Recap Summary- Month dated June 2025, had the following entry written by ULP-F "Resident was in his room at 8:55 p.m., and was gone around 9:15 p.m., employees drove around all over (owners names) drove all around until calling the cops. Sheriffs here with the drone and searching, found him." R4's Service Recap Summary- Month dated June 2025, July 2025, October 2025, and November 2025, respectively, lacked any safety checks on R4. R4's record lacked documentation R4 received safety checks three times per day. On November 20, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated CNS-B provided the surveyor with all of R4's documentation CNS-B was able to find in R4's paper chart and electronic medical record. On November 20, 2025, at 3:30 p. m., ULP-G stated there was no assigned task to the ULPs to	01640			

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01640	Continued From page 45 complete safety checks three times a day for R4. ULP-G stated staff just try to keep "tabs" on R4's whereabouts. The licensee's Contents of Service Plan dated May 1, 2025, indicated the licensee's residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN) and or other licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01640			
01760 SS=J	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to ensure medications were administered per prescriber orders for one of one resident (R3) observed	01760			

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01760	Continued From page 46 during medication administration. This resulted in an immediate correction order on November 21, 2025. This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on November 18, 2025, at 10:25 a.m., through 11:36 a.m., assisted living director in residency (ALDIR)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R3's diagnoses included diabetes. R3's Service Plan (Waiver)- Addendum to Contract dated January 1, 2025, indicated R3's services included blood glucose three times per day, and medication administration five times per day. R3's prescriber orders dated September 18, 2025, included the following orders: -Humalog (short-acting insulin) inject nine (9) units subcutaneous (under the skin) three times per day before meals. Hold for blood sugar (glucose) less than 120; and -Lantus (long-acting insulin) inject 20 units under the skin every morning R3's prescriber order dated October 23, 2025,	01760			

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01760	Continued From page 47 included Lantus inject 18 units under the skin every morning. R3's Med (medication) Admin (administration) Summary- Actual- Month dated September 2025, indicated Humalog inject 9 units subcutaneous before breakfast, lunch, and supper. Hold for blood sugar less than 120. R3's Med (medication) Admin (administration) Summary- Actual- Month dated October 2025, indicated Humalog inject 9 units subcutaneous before breakfast, lunch, and supper. Hold for blood sugar less than 120. Effective October 23, 2025, Lantus inject 18 units under the skin every morning. Hold if under 120. R3's Med (medication) Admin (administration) Summary- Actual- Month dated November 2025, indicated Humalog inject 9 units subcutaneous before breakfast, lunch, and supper. Hold for blood sugar less than 120. Lantus inject 18 units under the skin every morning. Hold if under 120. The surveyor reviewed R3's Med (medication) Admin (administration) Summary dated September 2025, October 2025, and November 2025, respectively, which indicated the following: -October 2, 2025, at 8:00 a.m., R3's blood glucose was 113, however, R3 was administered Humalog 9 units. -October 6, 2025, at 8:00 a.m., R3's blood glucose was 0. The notes had written "couldn't take as test strips are missing RN ordered more", R3 was not administered Humalog 9 units. -October 6, 2025, at 12:00 p.m., R3's blood glucose was not recorded, R3's Medication Administration Summary had written "Humalog-cant [sic] give." -October 6, 2025, at 5:00 p.m., R3's blood	01760			

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01760	Continued From page 48 glucose was not recorded, R3's Medication Administration Summary had written "Humalog-Skipped- med out of stock, Nurse notified." -October 7, 2025, at 8:00 a.m., R3's blood glucose was 88, however, R3's Medication Administration Summary was left blank and unknown if R3 was administered Humalog 9 units. -October 7, 2025, at 5:00 p.m., R3's blood glucose was not recorded, R3's Medication Administration Summary had written "Humalog-no test strips." -October 8, 2025, at 5:00 p.m., R3's blood glucose was 0. The notes had written "Could not do as no test strips" and R3's Medication Administration Summary had written "Humalog-Could not do as no test strips." -October 9, 2025, at 8:00 a.m., R3's blood glucose was 116. The notes had written "strips not in stalk", however, R3 was not administered Humalog. -October 9, 2025, at 12:00 p.m., R3's blood glucose was 116. R3's Medication Administration Summary had written "Humalog- strips not in, unable to test" and R3 was not administered Humalog. -October 17, 2025, at 12:00 p.m., R3's blood glucose was 123, however, R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-nurse said to hold." -October 24, 2025, at 12:00 p.m., R3's blood glucose was not recorded, however, R3's Medication Administration Summary was left blank and unknown if R3 was administered Humalog 9 units. -October 26, 2025, at 8:00 a.m., R3's blood glucose was 115, however, R3 was administered Humalog 9 units and Lantus 18 units. -October 28, 2025, at 12:00 p.m., R3's blood	01760			

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01760	Continued From page 49 glucose was 185, however, R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-morning blood sugar was too close to noon." -October 30, 2025, at 8:00 a.m., R3's blood glucose was 109, however, R3 was administered Lantus 18 units. -November 4, 2025, at 12:00 p.m., R3's blood glucose was 120, however, R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-blood sugar was 120." -November 8, 2025, at 8:00 a.m., R3's blood glucose was 138, however, R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-to low to give Humalog unsure if resident will eat." -November 9, 2025, at 8:00 a.m., R3's blood glucose was 130, however R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-Not given due to resident not eating breakfast." -November 10, 2025, at 8:00 a.m., R3's blood glucose 112, however, R3 was administered Humalog 9 units and Lantus 18 units. -November 11, 2025, at 8:00 a.m., R3's blood glucose was 128, however, R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-to low bs." -November 14, 2025, at 8:00 a.m., R3's blood glucose was 123, however, R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-hold on Humalog resident may or may not eat." -November 15, 2025, at 8:00 a.m., R3's blood glucose was 120, however, R3 was not administered Humalog 9 units and Lantus 18 units. R3's Medication Administration Summary had written "Humalog- blood sugar 120, Lantus-	01760			

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NAME OF PROVIDER OR SUPPLIER THE HUMMINGBIRD			STREET ADDRESS, CITY, STATE, ZIP CODE 7704 COLE AVE MEADOWLANDS, MN 55765		
(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
01760	Continued From page 50 blood sugar 120." -November 15, 2025, at 12:00 p.m., R3's blood glucose was 120, however, R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-blood sugar 120." -November 16, 2025, at 12:00 p.m., R3's blood glucose was 132, however, R3 was not administered Humalog 9 units. R3's Medication Administration Summary had written "Humalog-blood sugar for AM was taken late around 11." -November 18, 2025, at 8:00 a.m., R3's blood glucose was 76, however, R3 was administered Humalog 9 units and Lantus 18 units. -November 18, 2025, at 12:00 p.m., R3's blood glucose was 115, however, R3 was administered Humalog 9 units. -November 19, 2025, at 8:00 a.m., R3's blood glucose was 116, however, R3 was administered Lantus 18 units. -November 20, 2025, at 8:00 a.m., R3's blood glucose was 107, however, R3 was administered Humalog 9 units and Lantus 18 units. R3 's record lacked documentation of R3 's Humalog and Lantus being administered as prescribed. On November 20, 2025, at 9:05 a.m., the surveyor observed ULP-E monitor R3's blood glucose and obtain a blood glucose reading of 107. ULP-E verbalized blood glucose results to R3 and "stated no more pokes for you". ULP-E documented R3's blood glucose in R3's electronic record and documented R3's insulin were administered. On November 19, 2025, at 7:04 p.m., during a telephone interview, ULP-D stated ULP-D's training in medication administration by the licensee's previous RN consisted of watching Educare training videos, and training with other ULPs on the floor. ULP-D stated after ULP-D	01760			

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01760	Continued From page 51 worked with other ULPs for a couple of days, the licensee's previous RN only asked questions on one procedure and then signed ULP-D off on a competency check list allowing ULP-D to work independently including administering medications. On November 20, 2025, at 8:09 a.m., ULP-E stated upon hire, ULP-E had to complete Educare training (online training courses) and then trained on the floor with other ULPs. ULP-E stated when ULP-E was training on the floor with other ULPs, CNS-B would observe ULP-E during medication administration and sign ULP-E sign skills checklist. On November 21, 2025, at 9:12 a.m., during a telephone interview with CNS-B, CNS-B stated R3 had specific directions written on the Medication Administration Summary to hold Humalog and Lantus insulin if R3's blood glucose was 120 or below. CNS-B stated if R3's blood glucose recorded low then R3's insulin was held, staff were educated to document in the resident record what medication was held and the reason why the medication was not given. CNS-B stated she was not aware of insulin administration errors, only errors made on how medications not administered were documented. CNS-B stated sometimes the ULPs documented a medication as "late" rather than not administered. CNS-B stated some staff required additional training on how to correctly document when a medication was not administered as directed. CNS-B stated if a resident's medication was signed as administered, it would be proof the resident received the medication as prescribed, including insulin. The licensee's Training Unlicensed Personnel for	01760			

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01760	Continued From page 52 Medication, Treatment and Therapy Administration policy dated May 1, 2025, indicated before the registered nurse RN delegates the task of assistance with self-administration of medications or the task of medication administration, treatment and therapy the RN will instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01760			
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a prescription for continuous glucose monitor for one resident was not being used for another resident (R3) with blood glucose monitoring. 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).	01900			

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01900	Continued From page 53 The findings include: During entrance conference on November 18, 2025, at 10:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided blood glucose (sugar) monitoring for the residents at the facility. CNS-B stated each resident had their own blood glucose meter and supplies and the licensee had a blood glucose meter to use as back up if the resident's blood glucose meter was not working properly. R3's Resident Notes dated October 8, 2025, indicated R3 was out of test strips for R3's blood glucose meter and unlicensed personnel (ULP)-F borrowed test strips from another resident. ULP-F documented when attempting to test R3's blood glucose with another resident's test strips, the blood glucose meter read "error", so ULP-F called and left a message for the nurse and owner (O)-H and after 15 minutes with no response, called R3's hospice nurse. R3's notes indicated the hospice nurse would call the pharmacy to inquire about R3's glucose test strips. On November 20, 2025, at 2:00 p.m., CNS-B stated staff should not be using blood glucose test strips or supplies from other residents and should be using the licensee's owned blood glucose meter and supplies as a backup. The licensee's Disinfecting of Reusable Equipment and Surfaces policy dated May 1, 2025, indicated reusable equipment and environmental surfaces would be properly disinfected. Whenever possible, residents would have their own reusable equipment and the equipment would not be shared with other residents.	01900			

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01900	Continued From page 54 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident record all of the required content in the disposition of medications for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01910			

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01910	Continued From page 55 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: R1's diagnosis included Parkinson's Disease. R1's September 2025, Medication Administration Summary indicated R1 was scheduled and received the following medications: -carbidopa/levodopa 25/100 milligrams (mg) one tablet by mouth four times a day for Parkinson's Disease; -glipizide 10 mg one tablet by mouth twice a day for diabetes; -hydrochlorothiazide 12.5 mg one capsule daily for high blood pressure; -ropinirole 3 mg one tablet three times a day for Parkinson's Disease; -diclofenac 1% gel four times a day for pain relief; -Optase 0.25% one drop in both eyes three times a day for dry eyes; -calcium citrate 200 mg one tablet twice a day for supplementation; -ClearLax powder 17 grams (g) daily for constipation; -metformin 500 mg one tablet daily for diabetes; -tab-a-vite one tablet daily for supplementation; -aspirin 81 mg one tablet daily for heart health; -vitamin D3 25 micrograms (mcg) one tablet daily for supplementation. R1's prescriber orders dated June 2, 2025, included the above noted medications.	01910			

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01910	Continued From page 56 R1's Discharge Care Plan dated September 30, 2025, indicated R1 was admitted July 1, 2025, and discharged to another assisted living facility on September 30, 2025. R1's discharge summary indicated R1 received medication management and R1's medications were sent with R1 at the time of discharge. R1's Record of Inventory and Destruction of Controlled and Uncontrolled Medications record dated September 30, 2025, included documentation for the disposition of the medications noted above of the medication's name, strength, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition; however, lacked documentation of the medication prescription number, as applicable. In addition, R1's record lacked the documentation of the disposition of the following medications: diclofenac 1% gel, metformin 500 mg and Optase 0.25% eye drop. On November 18, 2025, at 1:33 p.m., clinical nurse supervisor (CNS)-B stated CNS-B had not been documenting medication prescription numbers and was not aware of the requirement. CNS-B confirmed R1's disposition record did not include the documentation of the disposition of R1's metformin, diclofenac gel or Optase eye drops. The licensee's Medication Disposal policy dated May 1, 2025, indicated upon disposition, the licensee would document in the resident record the name of the person to whom the medications were given, the time, date, the name of each medication and the amount of the medication remaining. The licensee's policy did not include documentation of the medication strength or	01910			

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01910	Continued From page 57 prescription number, where applicable as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	02040			

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02040	Continued From page 58 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 19, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care	02170			

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02170	Continued From page 59 plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan for three of three residents (R2, R3, R4) who had a diagnosis of dementia and resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 held an assisted living with dementia care license effective February 1, 2025, with an	02170			

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02170	Continued From page 60 expiration date of January 1, 2026. During entrance conference on November 18, 2025, at 10:25 a.m., assisted living director in residency (ALDIR)-A and clinical nurse supervisor (CNS)-B stated they were becoming familiar with the assisted living requirements. R2 R2's diagnoses included unspecified dementia with other behavioral disturbances. R2's Service Plan (Waiver)-Addendum to Contract dated November 4, 2025, indicated R2's services included bathing, dressing, grooming, transferring, medication administration, housekeeping and laundry. R2's Individualized Activity Plan dated October 20, 2025, included an evaluation of the activity areas which were required, however, R2's record did not include an individualized activity plan with structured and non-structured activities specific for R2. R3 R3 diagnoses included mild vascular dementia without behavioral disturbances. R3's Service Plan (Waiver)-Addendum to Contract dated January 1, 2025, indicated R3's services included bathing, dressing, grooming, catheter care, toileting, transferring, medication administration, blood glucose monitoring, safety checks, house keeping and laundry. On November 20, 2025, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-E monitor R3 blood glucose (sugar) at the dining	02170			

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02170	Continued From page 61 table with a blood glucose reading of 107. R3's Individualized Activity Plan dated September 9, 2025, included an evaluation of the activity areas which were required, however, R3's record did not include an individualized activity plan with structured and non-structured activities specific for R3. R4 R4's diagnoses included severe Alzheimer's dementia of other onset with mood disturbance, and hallucination. R4's Service Plan (Waiver)- Addendum to Contract dated December 17, 2024, indicated R4's services included bathing, dressing, grooming, medication administration, safety checks three times daily, housekeeping and laundry. R4's Individualized Activity Plan dated November 11, 2025, included an evaluation of the activity areas which were required, however, R4's record did not include an individualized activity plan with structured and non-structured activities specific for R4. On November 20, 2025, at 2:00 p.m., CNS-B stated CNS-B was not aware of all the requirements for a resident's individualized activity evaluation and activity plan. The licensee's Description of Life Enrichment Programs and how Activities are Supplemented in ALDC (Assisted Living Dementia Care) policy dated May 1, 2025, indicated each resident would be evaluated for activities. The evaluation plan must include: -past and current interests;	02170			

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02170	Continued From page 62 -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, the policy indicated an individualized activity plan must be developed for each resident based on their activity evaluation including structured and non-structured activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R3) who utilized side rails. This resulted in an immediate order for correction on November 20, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more	02310			

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02310	Continued From page 63 than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on November 17, 2025, at 10:25 a.m., through 11:36 a.m., the assisted living director in residency (ALDIR)-A and clinical nurse supervisor (CNS)-B stated the licensee did not have any residents that utilized side rails. ALDIR-A stated the licensee did not allow the use of side rails or consumer rails within the facility. R3 R3's diagnoses included history of cerebrovascular accident (CVA) with left sided weakness and is on palliative care (a specialized form of care that provides symptom relief, comfort and support to people living with serious or chronic illnesses). On November 19, 2025, at 8:46 a.m., during an observation of unlicensed personnel (ULP)-C and ULP-D assisting R3 with morning cares, the surveyor observed R3 had a side rail in the down position, attached to the right side of R3's electric bed and another side rail sitting on the floor between the wall and R3's stationary chair. ULP-C was making R3's bed and stated ULP-C had not noticed R3 had a side rail attached to the bed. ULP-C stated ULP-C did not know the licensee's procedures on side rail use or had been educated on reporting if a resident had a side rail attached to the bed.	02310			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 64 R3's Service Plan dated January 2, 2025, indicated R3 required assistance with dressing, grooming, bathing, toileting, transfers, bed mobility, medication administration, housekeeping and laundry. R3's 90 Day Assessment dated June 12, 2025, and September 9, 2025, indicated R3 required assist of one to two staff for bed mobility and transferred with a mechanical lift device with the assistance of two staff. R3's assessments indicated R3 had an electric bed, and no assistive devices were needed for R3's bed. R3's record lacked documentation R3 had a side rail including a comprehensive assessment on the use of an assistive device to include the use of side rails actual measurements of the entrapment zones and further lacked on going assessment for the use of an assisted device as required in the uniform assessment tool. On November 19, 2023, at 12:59 p.m., the surveyor and CNS-B observed R3's right side rail attached to R3's electric bed and another side rail on the floor between a chair and the wall. CNS-B stated CNS-B was unaware R3 had a side rail attached to the bed and had never observed the side rail in the upright position. CNS-B stated R3 re-started on hospice services a few months ago and it was likely the hospice agency supplied the side rail and did notify the licensee. On November 19, 2025, at approximately 1:45 p.m., ALDIR-A came into the office with R3's side rail and stated ALDIR-A removed R3's side rail because R3 had never been approved or assessed to have a side rail. ALDIR-A stated the licensee was unaware R3 had a side rail and side rails were not allowed in the facility. ALDIR-A	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER THE HUMMINGBIRD			STREET ADDRESS, CITY, STATE, ZIP CODE 7704 COLE AVE MEADOWLANDS, MN 55765		
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02310	Continued From page 65 stated the ULPs should have reported R3's side rail and if hospice had provided R3's side rail, the licensee was never informed. ALDIR-A stated the licensee would have to implement a new process to ensure staff were educated on reporting any resident was observed with a new assisted device. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated October 13, 2025 indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's bed rails includes, but is not limited to:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/24/2025
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02310	Continued From page 66 - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the	02310			

Minnesota Department of Health

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02310	Continued From page 67 registered nurse who conducted the assessment. The licensee's Assessing the Safety of Side Rails policy dated May 1, 2025, indicated the RN or licensed professional would train staff to be alert for any side rail or equipment that resemble side rail that a resident may be using or considering using to notify the RN Immediately about the side rail or equipment. When notified that a resident has a side rail the RN or licensed professional would assess and evaluate the resident's needs and assess to determine if the resident can safely utilize the side rail/equipment and determine whether the side rail/equipment meet the FDA standards for side rails. The RN or licensed professional would educate the resident, regarding the risks and benefits of side rails. If the side rail was determined not to meet the FDA guidelines, options and alternative for reducing falls or repositioning would be offered. The RN or licensed professional would review the use of the side rails every 90 days and written instructions regarding the side rails would be developed by the RN or licensed professional for the unlicensed staff. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/24/2025
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02320	Continued From page 68 and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication administration by two of two employees (unlicensed personnel (ULP)-C, ULP-E) not following the medication administration procedure. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on November 18, 2025, at 10:25 a.m. through 11:36 a.m., clinical nurse supervisor (CNS)-B stated CNS-B set up resident medications in a weekly medication planner on Wednesdays except for unscheduled medications and the ULPs were to take the medications from the medication planner for administration. On November 19, 2025, at 7:43 a.m., the surveyor observed ULP-C enter R3's room, put on gloves, unlock the medication cabinet, take the pills from the medication planner and place in a plastic cup, along with two vitamin gummies	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30728	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/24/2025
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02320	Continued From page 69 from a bottle and one pill that was set up in a separate medication planner. ULP-C stated the separate pill was a blood pressure pill and had specific directions for administering. ULP-C did not bring the computer when preparing R3's medications to verify in R3's EMAR (electronic medication administration record) the number of medications to be administered. ULP-C stated ULP-C knew R3 was to receive 10 pills every morning. On November 19, 2025, at 10:10 a.m., the surveyor observed ULP-C enter R5's room, put on a pair of gloves, unlock the medication cabinet and obtain two acetaminophen (pain reliever) tablets into ULP-C's gloved hand and exit the room. ULP-C obtained yogurt from the refrigerator and mixed the acetaminophen and yogurt together and administered to R5. ULP-C did not bring the computer when preparing R5's medications or verify medications in the EMAR prior to administering R5 medications. On November 20, 2025, at 7:45 a.m., the surveyor observed ULP-E enter R7's room, unlock R7's medication cabinet, dump the pills that were pre-set up in a medication planner into a clear plastic med cup, exited R7's room and administer R7's medications. ULP-E documented in the EMAR R7's mediations were administered. ULP-E stated she should have brought the computer and stand into R7's room to check the medications listed in the EMAR with the number of pills set up in the medication planner to make sure the number of the pills matched. ULP-E stated bringing the computer each room when administering medications was a new process and started during the survey. ULP-E stated ULP-E was not trained that way.	02320			

Minnesota Department of Health

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02320	Continued From page 70 On November 24, 2025, at 9:08 a.m., CNS-B stated CNS-B had only been working for the licensee since August 2025 and received little training by the previous RN. CNS-B stated CNS-B could not speak about how staff were trained by the previous RN but CNS-B stated CNS-B trained new staff to bring the computer with them when preparing resident medications to view the resident's EMAR and verify the number of the pills in the medication planner were the same number of pills listed in the resident EMAR. CNS-B stated CNS-B has observed poor medication administration technique and tried to provide on the spot training at the time of the observations. The licensee's Administration of Oral Medications policy dated May 1, 2025, indicated staff would check the Medication Administration Record (MAR) to see what times medications were to be administered. Staff would check for medication on the medication sheet that may not be in the medication dosage boxes (liquid medications, eye drops, ointments etc.). Check the dosage box and the label of any medications not in the the dosage box and compare them to the information on the MAR three times to make sure there were no mistakes made. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

THE HUMMINGBIRD
7704 COLE AVENUE
Meadowlands, MN 55765
St Louis County
Parcel:

Phone:

License Info

License: HFID 30728

Risk:
License:
Expires on:
CFPM: Zoe Laucamp-Larson
CFPM #: 62984; Exp: 11/18/2028

Inspection Info

Report Number: F1006251100
Inspection Type: Full - Single
Date: 11/19/2025 Time: 10:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: PACKAGE OF RAW BURGER WAS FINISHING THAWING IN A BIN WITH TWO PACKAGES OF SAUERKRAUT IN THE PANTRY REFRIGERATOR. STAFF WERE UNSURE WHAT THE USE FOR THE SAUERKRAUT WAS AND IF IT WAS GOING TO BE COOKED OR NOT. AS A PRECAUTION SAUERKRAUT WAS MOVED UP. DISCUSSED PROPER STORAGE OF ANY RAW PROTEINS.

Comply By: Complied On Site Originally Issued On: 11/19/2025

New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.12 Priority Level: Priority 3 CFP#: 37

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

COMMENT: FLOUR AND SUGARS WERE IN CONTAINERS WITHOUT LABELS. STAFF WERE INFORMED IMMEDIATELY AND MADE LABELS. REMINDER THAT EVERYTHING REMOVED FROM THE ORIGINAL CONTAINER NEEDS TO BE LABELED.

Comply By: Complied On Site Originally Issued On: 11/19/2025

New Order: 3-500A Microbial Control: cooling

3-501.13ABC Priority Level: Priority 3 CFP#: 35

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

COMMENT: A BRICK OF CHEESE WAS IN THE SINK SUBMERGED UNDERWATER. THE WATER WAS NOT RUNNING AND WAS 80F. SINCE DISHES ARE ALSO RINSED IN THESE SINKS RECOMMEND WORKING WITH STAFF TO THAW FOODS IN THE REFRIGERATOR. IF ITEMS NEED TO BE THAWED RECOMMEND PLACING IN BOWL OR CONTAINER IN THE SINK UNDER RUNNING WATER AT 70F OR LESS.

Comply By: 11/19/2025 Originally Issued On: 11/19/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: PROVIDE AN IRREVERSIBLE REGISTERING TEMPERATURE, SUCH AS A THERMOLABEL, TO MEASURE TEMPERATURE INSIDE THE DISH MACHINE TO HELP ENSURE IT IS REACHING AT LEAST 160F.

11/20/25 OWNER SENT PICTURE OF 3-TEMP THERMOLABELS THAT ARRIVED THAT DAY (11/20).

Comply By: 12/5/2025 Originally Issued On: 11/19/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: KITCHEN HAS BOTH QUAT AND CHLORINE BASED WIPES THAT THEY WILL USE IN THE KITCHEN, BUT DON'T HAVE EITHER TEST STRIP. DISCUSSED FINDING A SANITIZER FOR STAFF TO USE STRICTLY IN THE KITCHEN AND APPROVED FOR FOOD CONTACT SURFACES AND GETTING THE APPROPRIATE TEST STRIP FOR IT.

11/20/25 OWNER SENT PICTURE OF QUAT STRIPS THAT ARRIVED THAT DAY (11/20).

Comply By: 12/4/2025 Originally Issued On: 11/19/2025

Food & Beverage General Comment

COMMENTS:

INSPECTION ACCOMPANIED BY CHAR OBRECHT.

FOODS IN THE PANTRY REFRIGERATOR WERE SLIGHTLY ABOVE 41F (MILKS WERE 42). REFRIGERATOR HAD JUST BEEN OPENED FOR LUNCH PREP, BUT COOLER WAS ADJUSTED IMMEDIATELY AND DISCUSSED MONITORING TEMPS TO MAKE SURE FOODS ARE MAINTAINED AT 41F OR LOWER AT ALL TIMES.

SINCE THEY ARE NEWER OWNERS WENT THROUGH DAY TO DAY OPERATIONS AND GENERAL FOOD SAFETY PRACTICES WITH OWNER. DISCUSSED GOING THROUGH GENERAL BEST PRACTICES WITH ALL STAFF THAT WORK IN THE KITCHEN AND MAKING SURE POLICIES IN PLACE ARE BEING FOLLOWED. FOR EXAMPLE, STAFF ARE SUPPOSED TO BE PULLING FROZEN FOODS THE DAY BEFORE SO THEY THAW UNDER REFRIGERATION AND ARE THAWED FOR WHEN STAFF NEED THEM. STAFF HAD BEEN THAWING CHEESE IN THE SINK DURING THE INSPECTION BECAUSE IT WAS FROZEN AND NEEDED FOR LUNCH. ALSO, THERE IS A SIGN ON THE PANTRY STATING STAFF SHOULD BE USING DIFFERENT COLORED CUTTING BOARDS FOR DIFFERENT FOODS, BUT WHEN ASKED STAFF WEREN'T DOING IT AND WEREN'T AWARE IF THEY HAD THE COLORED CUTTING BOARDS. ZOE RECENTLY RECEIVED HER CFPM CERTIFICATE WORK WITH HER TO GO OVER STAFF TRAINING. VOMIT CLEAN UP POSTER, FOODS FOR HIGHLY SUSCEPTIBLE POPULATIONS FACT SHEET, AND LINK TO BUSINESS FOOD FACT SHEETS EMAILED WITH REPORT.

OBSERVED GOOD HAND WASHING AND GLOVE USE BY STAFF DURING THE INSPECTION. DISCUSSED THE IMPORTANCE OF PROPER HAND WASHING AND NO BARE HAND CONTACT WITH ALL READY TO EAT FOODS BY USING GLOVES, TONGS/UTENSILS, OR DELI TISSUE.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES HAVE BEEN DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY FOODBORNE ILLNESS COMPLAINTS. REMINDER ALL EMPLOYEE ILLNESS MUST BE RECORDED.

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 Duluth District Office inspection report number F1006251100 from 11/19/2025

Callie Harrison

John and Char Obrecht
Owners

Callie Harrison,
Public Health Sanitarian 3
218-302-6173
callie.harrison@state.mn.us



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Page: 1

Establishment Info

THE HUMMINGBIRD
Meadowlands
County/Group: St Louis County

Inspection Info

Report Number: F1006251100
Inspection Type: Full
Date: 11/19/2025
Time: 10:30 AM

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

Location: Upright Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN; Temperature Process: Cold-Holding

Location: Freezer (homestyle) at Degrees F.

Comment:

Violation Issued?: No

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

Location: Homestyle Refrigerator at 42 Degrees F.

Comment:

Violation Issued?: No

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

Location: Homestyle Refrigerator at 42 Degrees F.

Comment:

Violation Issued?: No



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Page: 1

Establishment Info

THE HUMMINGBIRD
Meadowlands
County/Group: St Louis County

Inspection Info

Report Number: F1006251100
Inspection Type: Full
Date: 11/19/2025
Time: 10:30 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wipes

Location: Kitchen **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 160 Degrees F.

Comment: STRIP TURNED BLACK

Violation Issued?: No

Food Establishment Inspection Report

 Duluth District Office Minnesota Department of Health 11 East Superior Street, Suite 290 Duluth, MN 55802	No. of Risk Factor/Intervention/Violations		1	Date: 11/19/2025
	No. of Repeat Risk Factor/Intervention/Violations			Time: 10:30 AM
	Score (optional)			Dur: min
Establishment: THE HUMMINGBIRD	Address: 7704 COLE AVENUE	City/State: Meadowlands, MN	Zip: 55765	Phone:
License/Permit #: HFID 30728	Permit Holder:	Purpose of Inspection: Full	Est. Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

GOOD RETAIL PRACTICES

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

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

ENGINEERING | ASSISTED LIVING

Project No: 30728016-0	Date: November 19, 2025
Facility Name: THE HUMMINGBIRD	
Facility Address: 7704 COLE AVENUE, MEADOWLANDS MN, 55765	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the locks. The egress control locks shall unlock upon loss of power controlling the lock or lock mechanism. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments:

- Electromagnetic locks with keypads were installed on the emergency exit doors. Assisted living director in residency (ALDIR)-A stated a signal or switch was not installed that had the capability to break power to these door locks. ALDIR-A stated procedures were not available for the operation of the controlled egress unlocking system.
- A wanderguard management system was installed on the exit door at the main entrance and the system did not have an emergency release button. ALDIR-A explained in an email that the wanderguard system was equipped with battery backup, so the door did not unlock upon loss of power.

3. Except as permitted by Section 1010.1.9.4, door handles, pulls, latches, locks and other operating devices on doors shall only require a single operation to release the door from the egress side. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.1]

Comments:

- A thumb turn style deadbolt lock was installed on the dining room exit door in addition to a controlled egress door locking system.

- A wander management system was installed on the main entrance exit door that was also equipped with a controlled egress door locking system.

4. Fire doors shall be maintained to be self-closing and latch as designed. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments: The door closer had been removed from the labeled one-hour fire door leading into the laundry room.

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

Comments: Burnt cigarettes had been disposed of on the patio and along the building foundation at the main entrance. Burnt cigarettes had been disposed of in the landscaping rocks near the designated employee smoking area.

6. Single-station and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: The smoke alarm in occupied resident sleeping room 9 did not work when tested by assisted living director in residency (ALDIR)-A.

7. Emergency lighting equipment shall be tested monthly for a duration of not less than 30 seconds. The test shall be performed manually or by an automated self-testing and self-diagnostic routine. Where testing is performed by self-testing and self-diagnostics, a visual inspection of the emergency lighting equipment shall be conducted monthly to identify any equipment displaying a trouble indicator or that has become damaged or otherwise impaired. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.10.1]

Comments: When the test button was pressed by assisted living director in residency (ALDIR)-A, the emergency lights did not operate in the shared facility living room and in the corridor outside resident room 3. ALDIR-A stated monthly emergency light tests had not been completed. The annual emergency lighting test record stickers were dated 2022.

8. Emergency and standby power systems shall be maintained in accordance with NFPA 110 and NFPA 111 such that the system is capable of supplying service within the time specified for the type and duration required. [Minn. Stat. 144G.45 subd. 2; MSFC 1203.4]

Comments: There was a permanently installed generator for the building. Assisted living director in residency (ALDIR)-A stated the generator was part of the emergency plan for loss of power. ALDIR-A stated records had not been maintained for generator inspections and testing. ALDIR-A stated the licensee was not aware weekly generator inspections and monthly load tests were required.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: When assisted living director in residency (ALDIR)-A tested the smoke alarms in resident sleeping rooms 2, 6, 7, and 8, none of the other dwelling unit smoke alarms were actuated.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: Assisted living director in residency (ALDIR)-A stated monthly portable fire extinguisher inspections were not completed. Inspections must be conducted every month and documented to ensure each installed extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments:

- The handle was missing from one side of the activity storage closet.
- The closet doorknob was missing in occupied resident room 2.
- There was damage to the wall surfaces in occupied resident room 9.
- On the exterior of the building, there was part of a hornet nest attached to a vent cover.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: Number identifiers were not posted for resident sleeping rooms 9, 10, and 11. The number identifier for resident room 6 was not visible as it was covered by decorations. The evacuation floor plan in the red emergency binder did not identify resident sleeping rooms. Resident sleeping room identifiers shall be visibly installed on or at all resident room doors and correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency.

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

Comments: The fire safety and evacuation plan included inaccurate information. Assisted living director in residency (LALDIR)-A stated the fire safety plan had not been updated since the change in ownership.

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

Comments: Resident instructions were limited to in the event of a real fire, evacuate the building.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The fire safety and evacuation plan lacked evacuation procedures for the individualized unique needs of residents.

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

Comments: Records for new hire employee training on the site specific fire safety and evacuation plan were not provided. Assisted living director in residency (ALDIR)-A stated employees had been completing online fire safety and evacuation training using a third party platform at the time of hire.

6. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Evacuation fire drills had not been documented since February 2025. No evacuation fire drill records were provided from March to November 2025.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Twenty One (21) days

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1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

Comments: A safety risk assessment with mitigation for the physical environment was not completed. Assisted living director in residency (ALDIR)-A provided a hazard vulnerability assessment for emergency preparedness from the previous owner.