Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

May 1, 2026

Licensee
Kind Hearts Assisted Living LLC
3430 Michael Ave
White Bear Lake, MN 55110

RE: Initial License Number 420437
Health Facility Identification Number (HFID) 41676
Project Number(s) SL41676015

Dear Licensee:

On April 21, 2026, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed January 15, 2026. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective May 1, 2026.

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

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 15, 2026, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on January 15, 2026, found not corrected at the time of the April 21, 2026, follow-up survey and/or subject to a penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - $500.00

The details of the violations noted at the time of this follow-up survey completed on April 21, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's 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).

IMPOSITION OF FINES:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under

this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41676	A. BUILDING: _____ B. WING _____	R 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEARTS ASSISTED LIVING LLC	3430 MICHAEL AVE WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#41676015-1 On April 9, 2026, to April 21, 2026, the Minnesota Department of Health conducted a revisit at the above provider to follow up on orders issued pursuant to a survey completed on January 15, 2026. At the time of the survey, there were 0 residents; 0 receiving services under the Provisional Assisted Living license. As a result of the revisit, the following orders were reissued.	{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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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

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{0 680}	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 20, 2026, the surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on January 15, 2026. On April 20, 2026, at approximately 11:00 a.m., unlicensed personnel (ULP)-C provided a binder and stated the contents were the licensee's EPP. The licensee's EPP dated September 17, 2025, lacked an individualized plan to include all the required content below: -lacked missing resident quarterly reviews; -subsistence needs for staff and residents; -procedures for tracking of staff and residents; - policies and procedures for medical documents; -LTC family notifications; and -EPP testing program. On April 20, 2026, at approximately 11:30 a.m., clinical nurse supervisor (CNS)-B and ULP-C acknowledged the licensee's EPP lacked the above listed required content. ULP-C stated the licensee hired a consultant to help with the licensee's plan of correction (POC) and the consultant was working on an updated EPP that would contain the required content for the licensee's EPP. ULP-C also stated the licensee was planning on testing the EPP soon. The licensee's Emergency Preparedness policy dated March 29, 2023, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that	{0 680}		

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{0 680}	Continued From page 3 disrupted services. The licensee's Missing Resident policy dated March 29, 2023, indicated the licensee would review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided.	{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:	{0 775}	Not reviewed during this survey.	
{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:	{0 790}	Not reviewed during this survey.	

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

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{0 810}	Continued From page 5 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 April 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	{0 810}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

February 26, 2026

Licensee
Kind Hearts Assisted Living LLC
3430 Michael Avenue
White Bear Lake, MN 55110

RE: Provisional Conditional License Number 420437
Health Facility Identification Number (HFID) 41676
Project Number SL41676015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 15, 2026, 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.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **May 27, 2026**.

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. The total amount of **potential** fines that may be assessed related to these correction orders is $1,500.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional 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 Kind Hearts Assisted Living LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. 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 Kind Hearts Assisted Living LLC is in substantial compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** Kind Hearts Assisted Living LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Kind Hearts Assisted Living LLC must provide the Department:

i. A list of the names and birthdates of any individuals Kind Hearts Assisted Living LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents including:
    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

c. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Kind Hearts Assisted Living LLC to correct the violations cited during the survey as well as to determine the overall practice of Kind Hearts Assisted Living LLC 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 provisional licensed assisted living services. The OOLTC will share their findings with MDH.

d. **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 provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

e. **Corrective Action Plan:** Kind Hearts Assisted Living LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Kind Hearts Assisted Living LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Kind Hearts Assisted Living LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Kind Hearts Assisted Living LLC. If MDH determines Kind Hearts Assisted Living LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license

under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration 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 Jess Schoenecker directly at: 651-201-3789 or email at: Jess.Schoenecker@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41676	A. BUILDING: _____ B. WING _____	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#41676015 On January 12, 2026, through January 15, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there was 1 resident; 1 receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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KIND HEARTS ASSISTED LIVING LLC	3430 MICHAEL AVE WHITE BEAR LAKE, MN 55110

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

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	41676	A. BUILDING: _____ B. WING _____	01/15/2026

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0 460	Continued From page 2 On January 12, 2026, at approximately 9:40 a.m., during the entrance conference, unlicensed personnel (ULP)-C stated the licensee did not have a call light or pendant system the residents could use to summon staff. ULP-C also stated residents would verbally call out to the licensee's staff if they needed assistance. On January 12, 2026, at approximately 10:20 a.m., during facility tour, the surveyor observed the facility was a two-level home with a main floor and lower level. The surveyor also observed no pendants, call light system, or means to request assistance were available in the residents' rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
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 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:	0 580		

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0 580	Continued From page 3 Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 12, 2026, at approximately 9:50 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated ongoing QMP areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. LALD/RN-A also stated he was recently hired by the licensee and started to develop a QMP program for the licensee. The licensee's Quality Improvement policy dated March 29, 2023, indicated a QMP would be implemented, and documentation would be provided upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

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0 630	Continued From page 4	0 630		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 was admitted on September 17, 2025. On January 12, 2026, at approximately 11:30 a.m., clinical nurse supervisor (CNS)-B stated R1's IAPP was included in R1's Assessment.	0 630		

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0 630	Continued From page 5 R1's Assessment dated September 17, 2025, indicated R1 was at risk to be abused and did not include: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On January 12, 2026, at approximately 3:15 p.m., CNS-B confirmed R1's IAPP did not include statements of specific measures to be taken to minimize risks. CNS-B stated the licensee was unaware of the required contents of the IAPP and would update R1's IAPP. The licensee's Vulnerable Adult policy dated March 29, 2023, indicated the licensee developed IAPPs that included the resident's susceptibility to be abused by another individual, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, and specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 6 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies as required by Minnesota Administrative Rule 4659.0190 Subpart 6 for two of two unlicensed personnel ((ULP)-B, ULP-C). 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: ULP-C was hired by the licensee on September 17, 2025.	0 650		

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0 650	Continued From page 7 ULP-C's record lacked documentation by a registered nurse of the required training and competencies related to Minnesota statute 144G.61 Subd. 2 (a) and (b). ULP-D was hired by the licensee on September 17, 2025. ULP-D's record lacked documentation by a registered nurse of the required training and competencies related to Minnesota statute 144G.61 Subd. 2 (a) and (b). On January 12, 2026, at approximately 10:00 p.m., during the entrance conference, licensed assisted living director/RN (LALD/RN)-A stated ULP-C and ULP-D performed cares which included RN delegated tasks on the residents. On January 12, 2026, at approximately 2:00 p.m., clinical nurse supervisor (CNS)-B stated ULP-C and ULP-D were fully trained, and competencies performed in all required areas. CNS-B also stated they remember doing the training but had not completed any documentation on the training or competencies. On January 13, 2026, at approximately 9:15 a.m., by phone interview, RN-E (previous CNS for licensee) stated ULP-C and ULP-D were fully trained and found competent within the first days of hire and before any services were provided to residents. RN-E also stated they did not know how to document ULP-C and ULP-D's training and competencies. The licensee's Personnel Records policy dated March 29, 2023, indicated competencies would be performed and documentation of training and	0 650		

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0 650	Continued From page 8 competencies would be maintained in each employee's respected records. Minnesota Administrative Rule 4659.0190 Subpart 6 published August 11, 2021, indicated all training and competencies must be documented and maintained in each employee's respective record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program	0 660		

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0 660	Continued From page 9 based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment, failed to complete TB history and symptom screen for two of four employees (unlicensed personnel (ULP)-C, ULP-D), and failed to complete TB testing for three of four employees (clinical nurse supervisor (CNS)-B, ULP-C, ULP-D). 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: TB FACILITY RISK ASSESSMENT On January 12, 2025, at approximately 9:50 a.m. during the entrance conference, CNS-B stated was recently hired and was unsure if the licensee had completed a facility TB risk assessment. By the end of the survey, the licensee could not provide any documents that indicated the licensee performed a facility TB risk assessment. CNS-B CNS-B had a hire date of October 17, 2025. CNS-B's employee record included one TB skin test dated November 7, 2025, but lacked documentation of a completed second TB skin test.	0 660		

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0 660	Continued From page 10 ULP-C ULP-C had a hire date of September 17, 2025. ULP-C's employee record lacked documentation of a TB history and symptom screen and a completed TB test at time of ULP-C's hire. ULP-D ULP-D had a hire date of September 17, 2025. ULP-D's employee record included one TB skin test dated October 14, 2025, but lacked documentation of a completed second TB skin test. ULP-D's employee record also lacked a TB history and symptom screen at time of ULP-D's hire. On January 12, 2026, at approximately 2:45 p.m., CNS-B verified two employee records lacked a TB history and symptom screen, and three employee records lacked a completed TB test upon hire. CNS-B stated the licensee was unaware of all the required TB requirements. The licensee's Tuberculosis Screening/Prevention policy dated March 29, 2023, indicated the licensee would complete a facility TB risk assessment, and baseline screening was completed at time of hire for all direct care providers and testing results would be kept in each employee medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom	0 660		

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0 660	Continued From page 11 screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses 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.	0 680		

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0 680	Continued From page 12 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 12, 2026, at approximately 11:00 a.m., unlicensed personnel (ULP)-C provided a binder and stated the contents were the licensee's EPP. The licensee's EPP dated September 17, 2025, lacked an individualized plan to include all the required content below: -missing resident quarterly reviews; -subsistence needs for staff and residents; -procedures for tracking of staff and residents; -policies and procedures including evacuation; -policies and procedures for sheltering; -policies and procedures for medical documents; -policies and procedures for volunteers; -arrangement with other facilities; -role under a waiver declared by secretary;	0 680		

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0 680	Continued From page 13 -methods for sharing information; -sharing information on occupancy/needs; -LTC family notifications; and -EPP prep training program. On January 12, 2026, at approximately 3:00 p.m., clinical nurse supervisor (CNS)-B and ULP-C acknowledged the licensee's EPP lacked the above listed required content. ULP-C stated the licensee was still learning all the EPP requirements and would update the EPP with the required information. The licensee's Emergency Preparedness policy dated March 29, 2023, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated March 29, 2023, indicated the licensee would review the missing resident plan at least quarterly and document any changes to the plan. 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:	0 775		

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0 775	Continued From page 14 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
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	0 790		

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0 790	Continued From page 15 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 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 January 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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	41676	A. BUILDING: _____ B. WING _____	01/15/2026

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0 810	Continued From page 16 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems	0 810		

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0 810	Continued From page 17 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 830		

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0 830	Continued From page 18 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 12, 2026, at 10:25 a.m., during a tour of the facility, the surveyor observed a designated smoking area outdoors next to the garage with a metal cigarette disposal receptacle located in the vicinity. On January 12, 2026, at approximately 10:30 a.m., the surveyor observed R1's room with cigarette ashes on top of a plastic storage container next to R1's bed. Licensed assisted living director/registered nurse (LALD/RN)-A acknowledged the ashes next to R1's bed. On January 12, 2026, at approximately 12:30 p.m., the surveyor observed R1's bathroom that was adjacent to R1's bedroom. R1's bathroom contained cigarette ashes on the floor next to the toilet and a cigarette butt that had been burned down to the filter of the cigarette that floated on top of the water inside the toilet. On January 12, 2026, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-B verified the cigarette butt and cigarette ashes in R1's bathroom. CNS-B stated R1 had been smoking indoors, and the licensee had discussed with R1 to not smoke cigarettes indoors. On January 12, 2026, at approximately 12:40 p.m., unlicensed personnel (ULP)-C provided an	0 830		

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0 830	Continued From page 19 untitled one-page form signed by R1, dated November 29, 2025, that indicated education on not smoking indoors. ULP-C stated the licensee's form was an attempt to prevent R1 from smoking indoors. R1 was admitted to the licensee on September 17, 2025, and resided in room one on the main level of the facility. R1's diagnoses included a history of a cerebrovascular accident. R1's signed Assisted Living Contract dated September 17, 2025, indicated on page four, section 10 Fire Safety, that there was no smoking in the licensee's facility. R1's record lacked a smoking assessment that identified if R1 could smoke safely and independently without interventions. R1's record included an incident report dated December 6, 2025, that indicated R1 was caught smoking in R1's bedroom and ashes were discovered in R1's bathroom toilet. On January 12, 2026, at approximately 3:20 p.m., CNS-B and ULP-C stated that the licensee was aware of R1's smoking habit and R1 had been smoking indoors in R1's room at various times. CNS-B and ULP-C also stated the licensee had tried to talk with R1 about smoking indoors and encouraged R1 to smoke outdoors in the facility's designated smoking area that was next to the garage. The licensee's Fire Safety policy dated March 29, 2023, indicated smoking was prohibited indoors and smoking was only allowed in the designated	0 830		

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0 830	Continued From page 20 smoking area. The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: 2 days	0 830		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1)	01530		

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01530	Continued From page 21 to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received eight hours of initial dementia care training and	01530		

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01530	Continued From page 22 two hours of mental illness and de-escalation training within the first 160 working hours of employment for direct care employees as required for two of two employees (unlicensed personnel (ULP)-C, ULP-D). 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: ULP-C ULP-C was hired on September 17, 2025, as the director in residency (DIR) and to provide direct care to the residents working full time (40 hours a week). The DIR permit for ULP-C ended on December 26, 2025, and at the time of ULP-C and ULP-D's hire, ULP-C was responsible for all the licensee's orientation. ULP-C had a total of 0 hours completed within 160 hours of working for the licensee. ULP-C's personnel record lacked the required eight hours of dementia care training and two hours of mental illness and de-escalation training within 160 hours of working for the licensee. ULP-D ULP-D was hired on September 17, 2025, to provide direct care to the residents working full time (40 hours a week). ULP-D had a total of 0 hours completed within	01530		

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01530	Continued From page 23 160 hours of working for the licensee. ULP-D's personnel record lacked the required eight hours of dementia care training and two hours of mental illness and de-escalation training within 160 hours of working for the licensee. On January 12, 2026, at approximately 3:10 p.m., ULP-C verified the initial dementia care training, mental illness and de-escalating training was not completed for all employees of the licensee. ULP-C stated the licensee thought the dementia training requirement only applied to assisted living facilities with a dementia care license. The licensee's Dementia Education policy dated March 29, 2023, indicated the licensee would meet the dementia care training requirements of direct care employees by completing at least eight hours of initial dementia training within 160 working hours of employment start date and direct care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01620		

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01620	Continued From page 24 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based 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.	01620		

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01620	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool, failed to ensure the RN conducted ongoing resident monitoring and reassessment no more than 14 days of initiation of services, and failed to complete a smoking assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 was admitted and started to receive services on September 17, 2025. UNIFORM ASSESSMENT TOOL R1's 14-Day [licensee] Reassessment Visit, dated October 19, 2025, and 90-day [licensee] Reassessment Visit, dated December 17, 2025, were two-page documents identified by clinical nurse supervisor (CNS)-B as R1's last two (2) consecutive RN assessments completed by the licensee. The assessments lacked a full physical and cognitive assessment as required on the uniform assessment tool per Minnesota Administrative Rule 4659.0140 Subp. 2. B. (3).	01620		

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01620	Continued From page 26 14-DAY ASSESSMENT R1's Initial Assessment was completed on September 17, 2025, with the next assessment due within 14 days or by October 1, 2025. R1's record included a subsequent 14-day assessment on October 19, 2025, which was 18 days past due. SMOKING ASSESSMENT On January 12, 2026, at 10:25 a.m., during a tour of the facility, the surveyor observed a designated smoking area outdoors next to the garage with a metal cigarette disposal receptacle half full of cigarette butts that had been burned down to the filter located in the vicinity. On January 12, 2026, at approximately 10:30 a.m., the surveyor observed R1's room with cigarette ashes on top of a plastic storage container next to R1's bed. Licensed assisted living director/registered nurse (LALD/RN)-A acknowledged the ashes next to R1's bed. On January 12, 2026, at approximately 12:30 p.m., the surveyor observed R1's bathroom that was adjacent to R1's bedroom. R1's bathroom contained cigarette ashes on the floor next to the toilet and a cigarette butt that had been burned down to the filter of the cigarette that floated on top of the water inside the toilet. On January 12, 2026, at approximately 12:35 p.m., clinical nurse supervisor (CNS)-B verified the cigarette butt and cigarette ashes in R1's bathroom. CNS-B stated R1 had been smoking indoors, and the licensee had discussed with R1 to not smoke cigarettes indoors. R1's record lacked a smoking assessment that	01620		

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01620	Continued From page 27 identified if R1 could smoke safely and independently without interventions. On January 12, 2026, at approximately 3:00 p.m., CNS-B stated the licensee performed a comprehensive assessment on residents upon admission that included all the elements of the uniform assessment tool, then used the two-page RN assessment for all other assessments during the year and was not aware of the Uniform Assessment Tool requirement for reassessments. CNS-B also stated the licensee was unsure why the 14-day reassessment was late as she had not worked for the licensee at that time. CNS-B further stated they were unaware of the smoking assessment requirement. The licensee's Comprehensive Nursing Assessment policy dated March 29, 2023, indicated the licensee would conduct and document a comprehensive assessment for all residents of the licensee that included smoking and safety factors. The licensee's Assessment and Reassessment policy dated March 29, 2023, indicated a RN comprehensive assessment would be conducted no more than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse,	01730		

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01730	Continued From page 28 advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 29 medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 was admitted on September 17, 2025, with diagnoses that included a history of a cerebrovascular accident. R1's Service Plan dated September 7, 2025, indicated R1 received medication management services. R1's [licensee] 90-day Reassessment Visit dated December 17, 2025, indicated R1 required assistance with medication management. R1's record lacked an individualized medication management record to include the following: -a description of storage of medications based on the resident's needs; -documentation of specific resident instructions	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41676	A. BUILDING: _____ B. WING _____	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEARTS ASSISTED LIVING LLC	3430 MICHAEL AVE WHITE BEAR LAKE, MN 55110

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01730	Continued From page 30 relating to the administration of medications; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed. On January 12, 2025, at approximately 3:10 p.m., clinical nurse supervisor (CNS)-B acknowledged the required content was lacking from residents' medication management records. CNS-B stated they were new to assisted living and was unaware of the requirements for the resident's medication management. The licensee's Medication Management Program policy, undated, indicated the required content would be included in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted 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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41676	A. BUILDING: _____ B. WING _____	01/15/2026

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KIND HEARTS ASSISTED LIVING LLC	3430 MICHAEL AVE WHITE BEAR LAKE, MN 55110

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01760	Continued From page 31 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document administration of medications according to provider orders for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 was admitted on September 17, 2025. R1's Signed Service Plan dated September 17, 2025, indicated R1 received services to include assistance with medications, medication reminders, and medication administration. R1's [licensee] 90-day Reassessment Visit dated December 17, 2025, indicated licensee's staff managed R1's medications. R1's medication administration record (MAR) dated October 2025, had missing charting on the following medications for the following dates: -amlodipine (lowers blood pressure) 10 milligrams (mg) once daily on October 5, 11, and 12; -aspirin (helps prevent blood clots) 81 mg once daily on October 5, 11, and 12;	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41676	A. BUILDING: _____ B. WING _____	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEARTS ASSISTED LIVING LLC	3430 MICHAEL AVE WHITE BEAR LAKE, MN 55110

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01760	Continued From page 32 -citalopram (antidepressant) 20 mg once daily on October 5, 11, and 12; -hydrochlorothiazide (lowers blood pressure) 25 mg once daily on October 11 and 12; and -atorvastatin (lowers cholesterol) 40 mg at bedtime on October 11, 12, and 31. R1's MAR dated November 2025, had missing charting on the following medications for the following dates: -Amlodipine 10 mg once daily on November 29 and 30; -Aspirin 81 mg once daily on November 29 and 30; -Citalopram 20 mg once daily on November 29 and 30; -Hydrochlorothiazide 25 mg once daily on November 29 and 30; and -Atorvastatin 40 mg at bedtime on November 1, 2, 3, 14, 24, and 29; R1's MAR dated December 2025, had missing charting on the following medication for the following date: -atorvastatin 40 mg at bedtime on December 29. R1's MAR dated January 2026, had missing charting on the following medications for the following dates: -Amlodipine 10 mg once daily on January 5 and 6; -Aspirin 81 mg once daily on January 5 and 6 -Citalopram 20 mg once daily on January 5 and 6; -Hydrochlorothiazide 25 mg once daily on January 5 and 6; and -Atorvastatin 40 mg at bedtime on 5. On January 12, 2026, at 3:10 p.m., clinical nurse supervisor (CNS)-B confirmed the missing medication documentation on R1's MARs.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41676	A. BUILDING: _____ B. WING _____	01/15/2026

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KIND HEARTS ASSISTED LIVING LLC	3430 MICHAEL AVE WHITE BEAR LAKE, MN 55110

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01760	Continued From page 33 CNS-B stated R1's medications were administrated but sometimes the staff forget to mark it down. CNS-B also stated the licensee would remind staff to document all medication administration on residents. The licensee's Medication Documentation policy dated March 29, 2023, indicated each medication administered by licensee staff would be documented in the resident's clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up was completed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41676	A. BUILDING: _____ B. WING _____	01/15/2026

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KIND HEARTS ASSISTED LIVING LLC	3430 MICHAEL AVE WHITE BEAR LAKE, MN 55110

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01770	Continued From page 34 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 12, 2026, at approximately 9:50 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication management services which included medication setup by CNS-B for their residents. On January 12, 2026, at approximately 10:25 a.m., during a tour of the facility, the surveyor observed a medication storage closet in the lower level of the facility that contained R1's medication pill bottles and a seven (7) day medication pill organizer. On January 12, 2026, at approximately 10:30 a.m., CNS-B stated the medications were removed from their original prescription bottles delivered by the pharmacy and placed in the pill organizer by CNS-B. CNS-B also stated she sets up R1's medications once a week in the pill organizer for the unlicensed personnel (ULP) to administer medications to R1. R1 was admitted on September 17, 2025, with diagnoses that included a history of a cerebrovascular accident. R1's Service Plan dated September 7, 2025, indicated R1 received medication management services. R1's [licensee] 90-day Reassessment Visit dated December 17, 2025, indicated R1 required assistance with medication management. R1's record lacked documentation for medication	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01770	Continued From page 35 setup at time of setup to include the dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. On January 12, 2026, at approximately 3:15 p.m., CNS-B acknowledged R1's record would not have documentation on R1's medication setups. CNS-B stated they were new to assisted living and were unaware of the requirements for documenting medication setups. The licensee's Medication Management Plan for Residents Away from Home policy dated March 29, 2023, indicated the licensee would document medication setups in the clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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

Food & Beverage Inspection Report

Establishment Info

Kind Hearts Assisted Living LLC
3430 Michael Ave
White Bear Lake, MN 55110
Ramsey County
Parcel:

Phone:

License Info

License: HFID 41676

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8058261016
Inspection Type: Full - Single
Date: 1/12/2026 Time: 11:27:11 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

HRD INSPECTOR CARL SAMROCK

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

41 GRAPES COOLER
160 - DISH MACHINE

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

I acknowledge receipt of the Metro District Office inspection report number F8058261016 from 1/12/2026

MOHA ADAM FELEMA
PIC

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41676015-0	**Date:** January 12, 2026
Facility Name: KIND HEARTS ASSISTED LIVING	
Facility Address: 3430 MICHAEL AVENUE, WHITE BEAR LAKE, MN 55110	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments:
   - The emergency escape floor plan labeled the door on the back of the building as an exit. A clear continuous egress path to the public right of way was not maintained free of snow.
   - In the basement, four windows were designated as emergency exits. Window well covers were installed that prevented these windows from opening.

3. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments: A cover was not installed on the electrical wall outlet behind the service sink in the basement laundry closet.

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

   Comments:
   - In the designated smoking area on the side of the garage, two burnt cigarettes were discarded on the ground and inside a broken flowerpot.
   - Cigarette ashes were disposed of on the floor next to the toilet in the shared bathroom for resident rooms one and two.

DEPARTMENT OF HEALTH

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: Monthly portable fire extinguisher inspections had not been completed. Fire extinguisher inspections shall be conducted and documented every month 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.

2. Portable fire extinguishers have a minimum 2-A:10-B:C rating within Group R-3 occupancies and travel distance to the nearest fire extinguisher does not exceed 75 feet. [Minn. Stat. 144G.45 subd.2]

   Comments: The portable fire extinguisher in the basement was rated 1A:10BC. Unlicensed personnel (ULP)-C stated this was a spare. All fire extinguishers must be the correct size and rating.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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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: Resident sleeping rooms were not accurately identified. The numbers posted at the resident room doors did not match the emergency escape floor plans. The number identifiers installed on or at the resident sleeping room doors need to correspond accurately 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 (FSEP) failed to provide site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. Record review of the available documentation indicated the following:
   - Portable fire extinguisher locations were inaccurately identified on the emergency escape floor plan.
   - The FSEP included fire safety instructions based on a RACE (Remove, Alarm, Confine, Extinguish/Evacuate) *template from a third party and inaccurately referenced pull fire alarms. The FSEP included a fire safety policy dated March 29, 2023, from a third party.*

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: Record review of the available documentation indicated the fire safety and evacuation plan failed to include site specific instructions for residents. The procedures were from a third party.

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: Record review of the available documentation indicated the fire safety and evacuation plan failed to include 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: The surveyor requested fire safety and evacuation plan employee training records at the time of hire from unlicensed personnel (ULP)-C. ULP-C stated this training had not been completed as they were unaware of this requirement.

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: The surveyor requested evacuation drill records from unlicensed personnel (ULP)-C. ULP-C stated these drills were not documented as they were unaware of this requirement.