



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 15, 2026

Licensee
Infinity Care Corp
14015 County Road 9
Minneapolis, MN 55447

RE: Project Number(s) SL36896016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER INFINITY CARE CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 14015 COUNTY ROAD 9 MINNEAPOLIS, MN 55447			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36896016-0 On July 27, 2026, through July 30, 2026, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six residents: two of whom received services under the 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 subd. 1, 2, and 3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing schedule was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470			

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0 470	Continued From page 2 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: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of four residents and had a current census of three residents. On July 27, 2026, at approximately 12:00 p.m., during a facility tour, the surveyor did not observe a posted staff schedule in any area of the facility, developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On July 27, 2026, at 12:00 p.m., housing manager (HM)-E stated the staffing schedule was posted in a locked medication room, but stated they were unable to find the posting in the medication room. On July 27, 2026, at approximately 12:20 p.m., licensed assisted living director (LALD)-D stated they had the staffing schedule posted on the wall but R2 had a history of removing postings from the wall. LALD-D provided a copy of the staffing schedule to the surveyor and stated it was a copy of the staffing schedule they had posted in the medication room.	0 470			

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
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 ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 630			

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0 630	Continued From page 4 The findings include: R1 R1 was admitted to the licensee on March 13, 2025, with diagnoses that included hypoxia. R1's admission assessment completed on March 3, 2025, indicated R1 received services for bathing, dressing, medication administration, and housekeeping. R1's IAPP completed on July 22, 2026, indicated R1 was at risk of being abused. R1's IAPP did not contain any specific measures to minimize the risk of abuse. R2 R2 was admitted to the licensee on August 9, 2023, with diagnoses that included schizoaffective disorder. R2's Service Plan signed and dated June 29, 2025, indicated R2 received services for bathing assistance, grooming, manage behavior, medication administration, and safety check. R2's IAPP completed on July 20, 2026, indicated R2 was at risk of being abused. R2's IAPP did not contain any specific measures to minimize the risk of abuse. On July 29, 2026, at approximately 2:50 p.m., clinical nurse supervisor (CNS)-C stated they were aware the specific measures to minimize the risk of abuse were supposed to be included in the IAPP, but it was missing from R1 and R2's IAPP due to an oversight. The Licensee's Vulnerable Adult policy dated August 1, 2021, indicated all residents admitted	0 630			

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0 630	Continued From page 5 to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. This includes self-abuse. The plan will be incorporated into the resident's care plan and will reflect their ability to participate in and direct their own care in the presence of an identified caregiver. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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	0 680			

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0 680	Continued From page 6 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 residents receiving services under the assisted living 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: The licensee's missing resident plan dated August 1, 2021, lacked evidence that the plan was reviewed quarterly. On July 29, 2026, at 1:11 p.m., licensed assisted living director (LALD)-D stated everything in the EPP including the missing resident plan was reviewed every six months. LALD-D stated they were not aware they had to review the missing resident plan quarterly. LALD-D also stated they did not do documentation for the six-month review.	0 680			

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0 680	Continued From page 7 The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly; and changes to the plan will be documented. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will 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. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=I	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	0 775			

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0 775	Continued From page 8 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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 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 July 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
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	0 810			

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0 810	Continued From page 9 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 810			

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0 810	Continued From page 10 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 July 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 910			

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0 910	Continued From page 11 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1's assisted living contract was signed on March 13, 2025. R2 R2's Assisted Living Contract was signed on November 7, 2024. R1 and R2's assisted living contract did not include the health facility identification number (HFID#) of the licensee's facility in a conspicuous place and manner on the contract. On July 28, 2026, at approximately 12:00 p.m., licensed assisted living director (LALD)-D stated they did not work for the licensee when the contracts were signed and stated they did not know the HFID was not listed. LALD-D stated they would make corrections to the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact	0 930			

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0 930	Continued From page 12 information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's assisted living contract was signed on March	0 930			

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0 930	Continued From page 13 13, 2025. R2 R2's Assisted Living Contract was signed on November 7, 2024. R1 and R2's assisted living contract lacked the right under section 144G.54 to appeal the termination of an assisted living contract. On July 28, 2026, at approximately 12:00 p.m., licensed assisted living director (LALD)-D stated they were not aware of the requirement to include the right to appeal termination in the contract. LALD-D stated they would make corrections to the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930			
01290 SS=D	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 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	01290			

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01290	Continued From page 14 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for one of eight employees (housing manager (HM)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: HM-E was hired on August 12, 2021, to provide direct care and services to residents and to provide oversight to unlicensed personnel (ULP). On July 28, 2026, at 10:00 a.m., the surveyor observed HM-E perform R2's medication administration. The licensee's NETStudy 2.0 roster (web-based system used to submit background study requests to the Department of Human Services (DHS)) did not include HM-E in the list of employees whose BGS were affiliated with the licensee's healthcare facility identification number (HFID) 36896. On July 30, 2028, at 10:20 a.m., licensed	01290			

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01290	Continued From page 15 assisted living (LALD)-D stated the licensee had two HFIDs for the same facility and the licensee had access to both HFIDs in NETStudy 2.0. The roster for HFID 35788 included HM-E in the list of employees whose BGS were affiliated. LALD-D stated they did not know why there were two HFIDs for the same facility. LALD-D stated the facility owner runs the BGS and the owner was out of the country. The surveyor was able to determine by reviewing internal Minnesota Department of Health (MDH) records that the licensee formerly held a comprehensive home care license (closed in 2024) with HFID 35788. Although the license type was closed with MDH, the NETStudy 2.0 roster, separately operated by DHS, remained open and accessible to the licensee. The licensee's Recruiting and Hiring policy dated August 1, 2021, indicated the criminal background check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: i. The director or designee is responsible for initiating the criminal background study for new employees; ii. NetStudy 2.0 (or current version) will be used for the background check; iii. The employee will be directed to locations established by DHS to obtain fingerprint scans; and iv. Employees will be instructed that photographic identification will be required. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

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01530	Continued From page 16	01530			
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if 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	01530			

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01530	Continued From page 17 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 two of five employees (unlicensed personnel (ULP)-B, housing manager (HM)-E) received at least two hours of initial training on mental illness and de-escalation topics within 160 working hours of their employment start date. 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: ULP-B ULP-B was hired on September 13, 2025, to provide direct care and services to residents. R1's medication administration record (MAR) for the month of July 2026, indicated ULP-B administered evening (PM) medications to R1 on July 26, 2026. ULP-B's record lacked evidence that ULP-B had received the initial two hours of trainings on topics related to mental illness and de-escalation within	01530			

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01530	Continued From page 18 160 working hours of employment start date. HM-E HM-E was hired on August 12, 2021, to provide direct care and services to residents and to provide oversight to ULP. On July 28, 2026, at 10:00 a.m., the surveyor observed HM-E perform R2's medication administration. HM-E's record included one hour of Mental Illness training completed on January 1, 2026. HM-E's record lacked evidence that HM-E had received the initial two hours of trainings on topics related to mental illness and de-escalation within 160 working hours of employment start date or by the effective date of August 1, 2025. HM-E's mental illness training record was one hour short of the required two hours mental illness and de-escalation training. On July 29, 2026, at approximately 3:00 p.m., licensed assisted living director (LALD)-D stated ULP-B and HM-E had worked over 160 hours. LALD-D also stated they were unsure why the above-mentioned training was not completed. The licensee's Dementia Education policy dated August 1, 2021, did not include a policy statement for mental illness and de-escalation training. 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	01620			

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01620	Continued From page 19 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620			

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01620	Continued From page 20 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the date of last assessment for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on March 13, 2025, with diagnoses that included hypoxia. R1's admission assessment completed on March 13, 2025, indicated R1 received services for bathing, dressing, medication administration, and housekeeping.	01620			

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01620	Continued From page 21 R1's resident record included admission assessment completed on March 13, 2025, and a 14-day assessment completed on March 30, 2025. The 14-day assessment was late by three days. R1's resident record also included 90-day nursing assessments dated December 22, 2025, March 25, 2026, and June 22, 2026. The assessment completed on March 25, 2026, was completed three days past the 90-day requirement. R2 R2 was admitted to the licensee on August 9, 2023, with diagnoses that included schizoaffective disorder. R2's Service Plan signed and dated June 29, 2025, indicated R2 received services for bathing assistance, grooming, manage behavior, medication administration, and safety check. R2's resident record included 90-day nursing assessments dated September 20, 2025, January 28, 2026, April 20, 2026, and July 20, 2026. The assessment completed on January 28, 2026, was completed 40 days past the 90-day requirement. The assessment completed on July 20, 2026, was completed one day past the 90-day requirement. On July 28, 2026, at 9:35 a.m., clinical nurse supervisor (CNS)-C stated they did not know why the 14-day assessment was not completed on time for R1 as they were not working for the licensee at that time. CNS-C stated the 90-day assessments for R1 and R2 were late because they were new to the job and they were not informed that assessments were supposed to be	01620			

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01620	Continued From page 22 completed every 90-days. CNS-C stated R2's assessment was late by one day because R2 was not available when they came in to do the assessment on day 90. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated resident reassessment, and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the residents and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640			

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01640	Continued From page 23 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan was signed and included all the required contents for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on March 13, 2025, with diagnoses that included hypoxia. R1's admission assessment completed on March 13, 2025, indicated R1 received services for bathing, dressing, medication administration, and housekeeping. R1's Assisted Living contract signed on March 13, 2025, included a service plan entitled Exhibit 2: Service Plan. However, the service plan did not include any of the services provided to R1. The	01640			

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01640	Continued From page 24 Home Health Aide Care Plan section of the service plan where the licensee had the opportunity to list the services provided was crossed off and a handwritten note read "Refer RTask [residex]". R3 R3 was admitted to the licensee On September 17, 2025, with diagnoses that included schizoaffective disorder and anxiety. R3's Service Plan (Waiver)- Addendum to Contract signed and dated January 14, 2026, indicated R3 received service for appointment reminders, bathing reminder, dressing, grooming, managing behavior, medication administration twice per day, and medication set up by the nurse two days a week. R3's Clinical Update Assessment completed on March 27, 2026, indicated R3 was independent for the following services: bathing, dressing, eating, mobility, and toileting. The assessment also indicated R3 managed their own medication ordering and setup and that R3 may safely self-administer medication. On July 29, 2026, at approximately 1:45 p.m., clinical nurse supervisor (CNS)-C stated they did not know they had to change and sign the service plan whenever there was change to the services provided. CNS-C stated their understanding was that the service plan was supposed to be signed every year. On July 29, 2026, at 1:46 p.m., licensed assisted living director (LALD)-D stated R3 was not billed for the services. LALD-D stated they did not know they had to attach the actual service plan (Residex document) to R1's contract (where it	01640			

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01640	Continued From page 25 said refer to Residex). On July 29, 2026, at 2:10 p.m., CNS-C stated they stopped R3's medication administration service around the end of March 2026 but had not edited the service plan to reflect the new changes. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan must be revised based as needed based on resident review or reassessment. The initial service plan and any revisions are signed by the licensee's representative and the resident or resident's representative, indicating agreement with the services to be provided. The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; b. The fees for services and the frequency of each service, according to the residents' current review or assessment and resident preferences; c. The identification of the staff or categories of staff who will provide the services; d. The schedule and methods of monitoring reviews or assessments of the resident; e. The schedule and method of monitoring staff providing services; and f. A contingency plan that includes the following: - Action to be taken if the scheduled service cannot be provided; - Information and method for a resident or resident's representative to contact the facility; - Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition;	01640			

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01640	Continued From page 26 - The identification of and information as to who has the authority to sign for the resident in an emergency; and - Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730			

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01730	Continued From page 27 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete and document medication reconciliation. The licensee also failed to implement the individualized medication management plan to monitor medication supply and reorder medication for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01730			

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01730	Continued From page 28 The findings include: R1 R1 was admitted to the licensee on March 13, 2025, with diagnoses that included hypoxia. R1's admission assessment completed on March 13, 2025, indicated R1 received services for bathing, dressing, medication administration, and housekeeping. R1's Individualized Medication Management Plan dated June 22, 2026, indicated nurses were responsible for monitoring medication supplies, reordering of medication, and making calls to the pharmacy to ensure on time delivery of medications. R1's medication administration record (MAR) for the month of July 2026, indicated epinephrine (daily) inject 0.3 milligram (mg) intramuscular each time if needed for allergic reaction was discontinued on July 27, 2026, at 8:18 a.m. R2 R2 was admitted to the licensee on August 9, 2023, with diagnoses that included schizoaffective disorder. R2's Service Plan signed and dated June 29, 2025, indicated R2 received services for bathing assistance, grooming, manage behavior, medication administration, and safety check. R2's most recent assessment completed on July 20, 2026, under Medication Management section, indicated nurses were responsible for monitoring medication supplies, and reordering of medications.	01730			

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01730	Continued From page 29 R2's MAR for the month of July 2026, indicated the following medications were discontinued on July 27, 2026: - aspirin low 81mg, one tablet daily; - Eliquis 5mg, two tablets twice a day; and - risperidone 1mg, one tablet twice a day. The MAR also indicated mirtazapine 15mg, one tablet at bedtime and olanzapine 10mg, one tablet at bedtime were started on July 27, 2026. R2's resident record included a signed E-Script New Prescription Request form faxed to the licensee on July 27, 2026, which included orders for the following medications: - busPIRone HCl 10mg oral tablet, take one tablet twice a day, written on July 24, 2026; - benztropine mesylate 1mg oral tablet, take one tablet daily, written on July 24, 2026; - divalproex sodium 250mg oral tablet delayed release; take one tablet daily, written on July 24, 2026; - divalproex sodium 500mg oral tablet delayed release; take one tablet daily, written on July 24, 2026; - Lexapro 10mg oral tablet, take one tablet daily, written on July 24, 2026; - mirtazapine 15mg oral tablet, take one tablet at bedtime, written on July 24, 2026; - olanzapine 10mg oral tablet, take one tablet at bedtime, written on July 24, 2026; and - propranolol HCL 10 mg tablet, take one tablet twice daily as needed, written on June 2, 2026. On July 28, 2026, at 10:06 a.m., during medication administration, the surveyor observed the following medications for R2's morning medication packed in a bubble pack: - divalproex 250mg tablet;	01730			

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01730	Continued From page 30 - escitalopram (Lexapro) 10mg tablet; - benztropine 1mg tablet; and - busPIRone HCl 10mg tablet. On July 28, 2026, at approximately 11:40 a.m., clinical nurse supervisor (CNS)-C stated they did not have a signed order to discontinue the above-mentioned discontinued medications, on July 27, 2026. CNS-C stated they spoke with the pharmacist yesterday on July 27, 2026, and that the pharmacist verbally stated that the above-mentioned medications were discontinued, therefore CNS-C discontinued the medication for R1 and R2. CNS-C stated the providers did not want to refill R2's prescriptions. The surveyor inquired about when the CNS found out about the provider not wanting to refill the medications. CNS-C answered that the pharmacist had informed them about R2's medications around February 2026, but they were unable to discontinue the medications due to Residex (electronic medical record system software) not working for them. CNS-C stated therefore they verbally informed the ULPs (unlicensed personnel) to chart as not given. CNS-C stated they checked the MARs for correctness weekly and daily. CNS-C was unable to provide a discontinued order for R2's medications they discontinued during the survey. R2's MAR indicated the following medications were not administered due to the medication being out of stock, "med out of stock, Nurse notified" on the following dates: - July 19, 25, and 26, 2026 - aspirin, risperidone and Eliquis- skipped - med out of stock nurse notified. The MAR indicated charting as these medications were either administered or skipped due to the resident being out of the building for the month of	01730			

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01730	Continued From page 31 June and July 2026, except for the dates mentioned above where it was as skipped - med out of stock nurse notified. On July 28, 2026, at approximately 12:10 p.m., CNS-C stated mirtazapine was not transcribed to the system because CNS was having issues with the system. Although it was not entered into the system, CNS-C stated they told the ULPs to chart mirtazapine as given in the note section. CNS-C stated they did not make a written communication or progress note regarding the changes. CNS-C further stated there was a charting issue but asserted residents had been getting what was prescribed to them by their providers. On July 28, 2026, at 12:26 p.m., CNS-C stated they discontinued R1's Epi pen because it expired in the middle of July 2026, and they called pharmacy for refill yesterday, (July 27, 2026). CNS-C did not have a physician order to discontinue the Epi pen. On July 28, 2026, at 12:39 p.m., the licensee's preferred pharmacy pharmacist (P)-F stated R2's aspirin was last filled on April 2, 2026, for 28 days. P-F stated they did not have discontinue order for R2's aspirin but the provider did not refill it. Eliquis was last dispensed on January 8, 2026, for 28 days with no refills and there was no discontinue order for Eliquis. Risperidone was discontinued on February 11, 2026, and replaced with olanzapine 10mg at bedtime. P-F stated the licensee contacted the pharmacy regarding R1's Epi pen on July 27, 2026, however they were unable to refill it as the prescription expired in March 2026. P-F stated there was no order to discontinue R1's Epi pen. On July 28, 2026, at 12:50 p.m., CNS-C stated	01730			

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01730	Continued From page 32 they thought they transcribed olanzapine to the MAR, but they did not. The surveyor inquired whether CNS-C had completed a medication reconciliation since when they said they thought they transcribed the olanzapine. CNS-C stated they did do medication reconciliation. The surveyor asked if they had caught that the olanzapine was not transcribed during the medication reconciliation. CNS-C stated they did notice it during the medication reconciliation, and they thought they switched olanzapine for Risperidone, but it did not happen. CNS-C stated they thought it was a system error and they stated they had talked to the licensed assisted living director to give them more authority in Residex. CNS-C stated the director did increase their authority in Residex, but they did not try to reenter the medications, "it just did not cross my mind I was getting distracted." On July 29, 2026, at 2:32 p.m., CNS-C stated they did not know why R2 was taking both Eliquis and aspirin. CNS-C stated Eliquis and aspirin were both usually used as blood thinner to prevent blood clotting. CNS-C stated stopping the medications abruptly was alarming to them and they stated that they set up an appointment for R2 to see their doctor but R2 missed the appointment; then R2 got to see his doctor but the medication refill was not addressed; and they did not know why it was not addressed. The surveyor asked if they had an after-visit summary (AVS) for R2's visit. CNS-C stated they did not. CNS-C stated the pharmacist informed them about refills not being addressed during the visit; they did not have any documentation. CNS-C stated staff misplaced the AVS and they called the provider's office to get a copy, but they were unable to get a hold of the provider. CNS-C stated they had not called the provider since then	01730			

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01730	Continued From page 33 because they were waiting for a call back. CNS-C stated they did not have any progress notes written for R2, "I do not write much progress note I did not know I was supposed to write progress note; I will print the progress note I have." On July 29, 2026, at 10:54 a.m., R2's providers office (PO)-G stated aspirin was refilled on February 12, 2026, for 90 days with no extra refills; and aspirin was refilled on September 4, 2025, for 90 days with no extra refills. PO-G stated there was no communication received about R2 since February 12, 2026. PO-G stated R2 was last seen at the clinic on May 7, 2026; they did not discuss aspirin and Eliquis during this visit, they discussed an entirely different issue. On July 29, 2026, at 2:45 p.m., CNS-C stated since they did not have Epi pen supply for R1, their plan was to call 911 in case of emergency. On July 30, 2026, at approximately 9:15 a.m., CNS-C provided the surveyor with a blank page for R2's progress notes - Nurses Note dated January 1, 2026, through July 30, 2026. On July 29, 2026, at 11:55 a.m., housing manager (HM)-E stated they were aware the above-mentioned medications were out of stock and they stated they notified CNS-C that the medications were out of stock. HM-E stated they did not remember when they notified the CNS, but they stated that the CNS told them that they would call the pharmacy. On July 29, 2026, at 12:52 p.m., the surveyor asked why ULP-A had charted aspirin, Eliquis, and risperidone as given when there was no supply and why they never charted olanzapine as given although the pharmacy had been	01730			

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01730	Continued From page 34 dispensing olanzapine since February 2026. ULP-A stated it was a mistake, ULP-A also stated they usually check the correctness of the medication before they administer medication. R1 and R2's records lacked evidence a medication reconciliation was completed by the nurse. R2's medication administration did not reflect the accurate list of medication for the ULPs to follow. The surveyor could not discern whether the discontinued medications were purposefully discontinued by the physician or not refilled due to expired prescription. The licensee's Medication administration policy dated August 1, 2021, indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. 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	01760			

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01760	Continued From page 35 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders were accurately documented and transcribed to the medication administration record for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 27, 2026, at approximately 11:30 a.m., clinical nurse supervisor (CNS)-C stated prescribed orders were communicated to the nurse via fax or electronic prescriptions from pharmacy. CNS-C stated they would transcribe the orders and place the order in the resident's file. R1 R1 was admitted to the licensee on March 13, 2025, with diagnoses that included hypoxia. R1's admission assessment completed on March 13, 2025, indicated R1 received services for	01760			

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01760	Continued From page 36 bathing, dressing, medication administration, and housekeeping. R1's medication administration record (MAR) for the month of July 2026, indicated epinephrine (daily) inject 0.3 milligram (mg) intramuscular each time if needed for allergic reaction was discontinued on July 27, 2026, at 8:18 a.m. R2 R2 was admitted to the licensee on August 9, 2023, with diagnoses that included schizoaffective disorder. R2's Service Plan signed and dated June 29, 2025, indicated R2 received services for bathing assistance, grooming, manage behavior, medication administration, and safety check. R2's MAR for the month of July 2026, indicated the following medications were discontinued on July 27, 2026: - aspirin low 81mg, one tablet daily; - Eliquis 5mg, two tablets twice a day; and - risperidone 1mg, one tablet twice a day. The MAR also indicated mirtazapine 15mg, one tablet at bedtime and olanzapine 10mg, one tablet at bedtime were started on July 27, 2026. R2's MAR indicated the following medications were not administered due to the medication being out of stock, "med out of stock, Nurse notified" on the following dates: - July 19, 25, and 26, 2026 - aspirin, risperidone and Eliquis- skipped - med out of stock nurse notified. The MAR indicated charting as these medications were either administered or skipped due to the	01760			

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01760	Continued From page 37 resident being out of the building for the month of June and July 2026, except for the dates mentioned above where it was as skipped - med out of stock nurse notified. R2's resident record included a signed E-Script New Prescription Request form faxed to the licensee on July 27, 2026, which included orders for the following medications: - busPIRone HCl 10mg oral tablet, take one tablet twice a day, written on July 24, 2026; - benztropine mesylate 1mg oral tablet, take one tablet daily, written on July 24, 2026; - divalproex sodium 250mg oral tablet delayed release; take one tablet daily, written on July 24, 2026; - divalproex sodium 500mg oral tablet delayed release; take one tablet daily, written on July 24, 2026; - Lexapro 10mg oral tablet, take one tablet daily, written on July 24, 2026; - mirtazapine 15mg oral tablet, take one tablet at bedtime, written on July 24, 2026; - olanzapine 10mg oral tablet, take one tablet at bedtime, written on July 24, 2026; and - propranolol HCL 10 mg tablet, take one tablet twice daily as needed, written on June 2, 2026. On July 28, 2026, at 10:06 a.m., during medication administration, the surveyor observed the following medication for R2's morning medication packed in a bubble pack: - divalproex 250mg tablet; - escitalopram (Lexapro) 10mg tablet; - benztropine 1mg tablet; and - busPIRone HCl 10mg tablet. On July 28, 2026, at approximately 11:40 a.m., CNS-C stated they did not have an order to discontinue the above-mentioned discontinued	01760			

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01760	Continued From page 38 medications, on July 27, 2026. CNS-C stated they spoke with the pharmacist yesterday on July 27, 2026, and the pharmacist verbally stated that the above-mentioned medications were discontinued, therefore CNS-C discontinued the medication for R1 and R2. CNS-C stated the providers did not want to refill R2's prescriptions. The surveyor inquired about when the CNS found out about the provider not wanting to refill the medications. CNS-C answered the pharmacist had informed them about R2's medications around February 2026, but they were unable to discontinue the medications due to Residex (electronic medical record system software) not working for them. CNS-C stated they informed the unlicensed personnel (ULP) to chart as not given. R2's MAR indicated the following medications were not administered due to the medication being out of stock, "med out of stock, Nurse notified" on the following dates: - July 19, 25, and 26, 2026 - aspirin, risperidone and Eliquis- skipped - med out of stock nurse notified. The MAR indicated charting as these medications were either administered or skipped due to the resident being out of the building for the month of June and July 2026, except for the dates mentioned above where it was as skipped - med out of stock nurse notified. On July 28, 2026, at approximately 12:10 p.m., CNS-C stated mirtazapine was not transcribed to the system because CNS was having issues with the system. Although it was not entered into the system, CNS-C stated they told the ULP to chart mirtazapine as given in the note section. CNS-C stated they did not make a written communication or progress note written regarding the changes. CNS-C further stated there was a charting issue	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER INFINITY CARE CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 14015 COUNTY ROAD 9 MINNEAPOLIS, MN 55447		
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01760	Continued From page 39 but asserted residents had been getting what was prescribed to them by the providers. On July 28, 2026, at 12:26 p.m., CNS-C stated they discontinued R1's Epi pen because it expired in the middle of July 2026, and they called pharmacy for refill yesterday, (July 27, 2026). CNS-C did not have a physician order to discontinue the Epi pen. The surveyor could not discern whether the discontinued medications were purposefully discontinued by the physician or not refilled due to expired prescription. On July 28, 2026, at 12:39 p.m., the licensee's preferred pharmacy pharmacist (P)-F stated aspirin was last filled on April 2, 2026, for 28 days. P-F stated they did not have discontinue order for R2's aspirin but the provider did not refill it. Eliquis was last dispensed on January 8, 2026, for 28 days with no refills and no discontinue order for Eliquis. Risperidone was discontinued on February 11, 2026, and replaced with olanzapine 10mg at bedtime. P-F stated the licensee contacted the pharmacy regarding R1's Epi pen on July 27, 2026, however they were unable to refill it as the prescription expired in March 2026. P-F stated they contacted the provider and the licensee regarding the above-mentioned medications multiple times but did not get a response. On July 28, 2026, at 12:50 p.m., CNS-C stated they thought they transcribed olanzapine to the MAR, but they did not. The surveyor inquired whether CNS-C had completed a medication reconciliation since when they said they thought they transcribed the olanzapine. CNS-C stated they did do medication reconciliation. The	01760			

Minnesota Department of Health

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01760	Continued From page 40 surveyor asked if they had caught that the olanzapine was not transcribed during the medication reconciliation. CNS-C stated they did notice it during the medication reconciliation, and they thought they switched olanzapine for Risperidone, but it did not happen. CNS-C stated they thought it was a system error and they stated they had talked to the licensed assisted living director to give them more authority in Residex. CNS-C stated the director did increase their authority in Residex, but they did not try to reenter the medications, "it just did not cross my mind I was getting distracted." Although aspirin was last dispensed by pharmacy for 28 days on April 2, 2026, to last through April 30, 2026, R2's MAR indicated charting that aspirin was administered on multiple days in June and July 2026. R2's Eliquis was last dispensed by pharmacy for 28 days on January 8, 2026, to last through February 5, 2026, but R2's MAR for June and July 2026, indicated charting as Eliquis was being administered to R2 on multiple days. Although Risperidone was discontinued on February 11, 2026, and replaced with olanzapine 10mg, R2's MAR for the months of July indicated a charting that risperidone was being given to R2 until July 26, 2026, and olanzapine was started on July 27, 2026. On July 29, 2026, at 11:55 a.m., housing manager (HM)-E stated they were aware the above-mentioned medications were out of stock and they stated they notified CNS-C that the medications were out of stock. HM-E stated they did not remember when they notified the CNS, but they stated that the CNS told them that they would call the pharmacy. On July 29, 2026, at 12:52 p.m., the surveyor	01760			

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01760	Continued From page 41 asked why ULP-A had charted aspirin, Eliquis and risperidone as given when there was no supply and never charted olanzapine as given although the pharmacy had been dispensing olanzapine since February 2026. ULP-A stated it was a mistake, ULP-A also stated they usually check the correctness of the medication before they administer medication. The licensee's Medication administration policy dated August 1, 2021, indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain current physician orders for currently prescribed or discontinued medications for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01820			

Minnesota Department of Health

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01820	Continued From page 42 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 R1 was admitted to the licensee on March 13, 2025, with diagnoses that included hypoxia. R1's admission assessment completed on March 13, 2025, indicated R1 received services for bathing, dressing, medication administration, and housekeeping. R1's medication administration record (MAR) for the month of July 2026, indicated epinephrine (daily) inject 0.3 milligram (mg) intramuscular each time if needed for allergic reaction was discontinued on July 27, 2026, at 8:18 a.m. R2 R2 was admitted to the licensee on August 9, 2023, with diagnoses that included schizoaffective disorder. R2's Service Plan signed and dated June 29, 2025, indicated R2 received services for bathing assistance, grooming, manage behavior, medication administration, and safety check. R2's MAR for the month of July 2026, indicated the following medications were discontinued on July 27, 2026: - aspirin low 81mg, one tablet daily; - Eliquis 5mg, two tablets twice a day; and	01820			

Minnesota Department of Health

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01820	Continued From page 43 - risperidone 1mg, one tablet twice a day. The MAR also indicated Mirtazapine 15mg, one tablet at bedtime and Olanzapine 10mg, one tablet at bedtime were started on July 27, 2026. R2's resident record included a signed E-Script New Prescription Request form faxed to the licensee on July 27, 2026, which included orders for the following medication: - busPIRone HCl 10mg oral tablet, take one tablet twice a day; - benztropine Mesylate 1mg oral tablet, take one tablet daily; - divalproex sodium 250mg oral tablet delayed release; take one tablet daily; - divalproex sodium 500mg oral tablet delayed release; take one tablet daily; - Lexapro 10mg oral tablet, take one tablet daily; - mirtazapine 15mg oral tablet, take one tablet at bedtime; - olanzapine 10mg oral tablet, take one tablet at bedtime; and - propranolol HCL 10 mg tablet, take one tablet twice daily as needed. On July 28, 2026, at 10:06 a.m., during medication administration, the surveyor observed the following medication for R2's morning medication packed in a bubble pack: - divalproex 250mg tablet; - escitalopram (Lexapro) 10mg tablet; - benztropine 1mg tablet; and - busPIRone HCl 10mg tablet. On July 28, 2026, at approximately 11:40 a.m., clinical nurse supervisor (CNS)-C stated they did not have an order to discontinue the above-mentioned medications. CNS-C stated they spoke with the pharmacist yesterday on July	01820			

Minnesota Department of Health

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01820	Continued From page 44 27, 2026, and the pharmacist verbally stated that the above-mentioned medications were discontinued, therefore CNS-C discontinued the medication for R1 and R2. CNS-C stated the providers did not want to refill R2's prescriptions. The surveyor inquired about when the CNS found out about the provider not wanting to refill the medications. CNS-C answered the pharmacist had informed them about R2's medications around February 2026, but they were unable to discontinue the medications due to Residex (electronic medical record system software) not working for them. CNS-C stated they informed the unlicensed personnel (ULP) to chart as not given. On July 28, 2026, at 12:26 p.m., CNS-C stated they discontinued R1's Epi pen because it expired in the middle of July 2026, and they called pharmacy for refill yesterday, (July 27, 2026). CNS-C did not have a physician order to discontinue the Epi pen. On July 28, 2026, at 2:07 p.m., CNS-C stated they did not have prescription for any of their residents before yesterday, July 27, 2026 (survey start date). CNS-C stated they used after visit summaries (AVS), but they did not know if the AVS' were tossed away, and they did not have any of the AVS'. The licensee's Medication administration policy dated August 1, 2021, indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
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01820	Continued From page 45 TIME PERIOD FOR CORRECTION: Seven (7) days	01820			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

INFINITY CARE CORP
14015 County Road 9
Plymouth, MN 55441
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36896

Risk:
License:
Expires on:
CFPM: MOHAMED MOHAMED
CFPM #: FM61597; Exp: 09/23/2028

Inspection Info

Report Number: F8087261145
Inspection Type: Full - Single
Date: 7/27/2026 Time: 12:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR DEE MOISSISSA.

THE FOLLOWING OBSERVATIONS WERE MADE:

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

FLOORS: LAMINATE PLANK - NON COMPLIANT

COUNTERTOPS: LAMINATE - NON COMPLIANT

CABINETS: WOOD - NON COMPLIANT

REFRIGERATOR/FREEZER: FRIGIDARE

DISHWASHER: MAYTAG

STOVE/RANGE: FRIGIDARE

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

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

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

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

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 F8087261145 from 7/27/2026

John Boettcher

TARIK OMAR
CLINICAL NURSE SUPERVISOR

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info

INFINITY CARE CORP
Plymouth
County/Group: Hennepin County

Inspection Info

Report Number: F8087261145
Inspection Type: Full
Date: 7/27/2026
Time: 12:00:00 PM

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

Location: Upright Freezer at 9 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 36 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 36 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 36 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36896016-0	Date: July 28, 2026
Facility Name: INFINITY CARE CORP	
Facility Address: 14015 County Road 9, Minneapolis, MN 55447 (Plymouth)	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 3; Widespread TIME PERIOD OF CORRECTION: Seven (7) days

1.

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

A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: The evacuation map indicated an exit path from the Kitchen through the garage to exit. The exit path shall not indicate exiting through the garage in the event of a fire or similar emergency as this space is a higher hazard space than the assisted living.
3.

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: Evidence of unsafe smoking practices in resident rooms 2 and 3. Burn marks and tobacco ash were present on the windowsills and nightstands, and residents had discarded cigarette butts into water bottles and onto adjacent combustible surfaces. Staff acknowledged they were aware of the ongoing smoking issues involving these residents.
4.

Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

Comments: The smoke alarm devices provided throughout the facility did not display any indication that they were listed to underwriter laboratories (UL) standards to comply with requirements.

☒ **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 (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to maintain their FSEP as readily available. The licensee provided multiple policies for the surveyor to review. LALD-C indicated which policy they train on and use in the event of a fire. The policy should be cleaned up and organized so that only relevant policies and procedures are included to avoid confusion for staff and residents.

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

Comments: Licensee's FSEP failed to include site-specific resident actions relative to the facility's building layout, evacuation routes, and ways to remove residents. Resident evacuation procedures included shelter in place. The facility was not designed to provide shelter in place protection, and was lacking smoke compartments, fire rated doors, and a sprinkler system.