



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

January 14, 2026

Licensee

Minnesota Healthcare Services LLC
5126 Long Lake Road
Mounds View, MN 55112

RE: Denial of License Number 420542
Health Facility Identification Number (HFID) 41247
Initial survey; Project Number SL41247015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on December 4, 2025, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **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>

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Casey DeVries, via email at: Casey.DeVries@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care **no later than January 17, 2026**.

Pursuant to Minn. Stat § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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.

If you have any additional questions, please do not hesitate to contact Casey DeVries, Supervisor, at Casey.DeVries@state.mn.us. Casey DeVries can also be reached by office phone at 651-201-5917.

Sincerely,

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

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41247	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5126 LONG LAKE ROAD MOUNDS VIEW, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER 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: SL41247015-0 On December 1, 2025, through December 4, 2025, 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 two residents; two receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on December 2, 2025, issued for SL41247015-0, tag identification 0800. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on December 2, 2025, issued for SL41247015-0, tag	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000			
0 420 SS=I	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. 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:	0 420			

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0 420	Continued From page 2 The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence f a management agreement or subcontract." - "I have examined this application and all	0 420			

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0 420	Continued From page 3 attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window) and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page 18 was electronically signed by LALD-C on March 1, 2024. The licensee had a provisional assisted living license issued on April 11, 2025, with an expiration date of April 10, 2026. As a result of this survey, the following orders were issued 0420, 0470, 0480, 0485, 0490, 0500, 0510, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 1290, 1320, 1330, 1470, 1530, 1610, 1620, 1730, 1820, 1880, 1890, 1960, and 2320, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

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0 470	Continued From page 4 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted as required, potentially affecting the licensee's current residents and any visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	0 470			

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0 470	Continued From page 5 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 lacked a daily staffing schedule developed by the clinical nurse supervisor per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180 Subp. 4. 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 in each building. On December 1, 2025, at 11:11 a.m., during a tour of the facility, the surveyor observed the licensee's posted documents. There was no evidence of a staff schedule posting. On December 4, 2025, at 1:45 p.m., licensed assisted living director (LALD)- C stated they were aware of the requirement for the employee schedule to be posted. LALD-C stated they were not aware the weekly schedule was not posted and would promptly bring it to the attention of the housing manager. The licensee's undated document titled "Minnesota Healthcare Services LLC Forms Manual" contained a page titled "Items to be Posted in Assisted Living Residences". This list indicated the daily staffing schedule would be posted in a public area.	0 470			

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0 470	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part	0 480			

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

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0 480	Continued From page 8 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all	0 485			

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0 485	Continued From page 9 residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 1, 2025, at 11:11 a.m., during a tour of the facility, the surveyor observed the licensee's posted documents. There was no evidence of a weekly menu posted. On December 4, 2025, at 1:45 p.m., licensed assisted living director (LALD)- C stated they were aware of the requirement for the menu to be posted. LALD-C stated they thought it was posted near the kitchen area of the facility and was not aware the weekly menu was not currently posted. The licensee's undated document titled "Minnesota Healthcare Services LLC Forms Manual" contained a page titled "Items to be Posted in Assisted Living Residences". This list indicated the weekly menu would be posted in a public area. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services	0 490			

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0 490	Continued From page 10 All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, which create opportunities for active participation in the community at large. This had the potential to affect all five residents of the facility. This practice resulted in a level two violation (a	0 490			

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0 490	Continued From page 11 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 December 1, 2025, at 11:11 a.m., during a tour of the facility, the surveyor observed the licensee's posted documents. There was no evidence of a posted schedule of social and recreational activities. The licensee's undated document titled "Minnesota Healthcare Services LLC Forms Manual" contained a page titled "Items to be Posted in Assisted Living Residences". The list failed to indicate the requirement of the licensee to provide a posted schedule of social and recreational activities in a public area. On December 4, 2025, at 1:45 p.m., licensed assisted living director (LALD)-C stated they were aware of the requirement for the activity schedule to be posted. LALD-C stated they were not aware the activity schedule was not posted and would promptly bring it to the attention of the housing manager. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490			

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NAME OF PROVIDER OR SUPPLIER MINNESOTA HEALTHCARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 5126 LONG LAKE ROAD MOUNDS VIEW, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 500	Continued From page 12	0 500			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or	0 500			

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0 500	Continued From page 13 licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 2, 2025, at 11:19 a.m., in response to a request for the licensee's policies and procedures made on December 1, 2025, at 11:56 a.m., housing manager (HM)-A provided the surveyor with a file titled "Our forms". The provided information lacked required policies and procedures. The licensee failed to provide the following policies and procedures during or after the survey process: - conducting initial evaluations of residents' needs and the providers' ability to provide those services; - conducting initial and ongoing resident evaluations and assessments of resident needs,	0 500			

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0 500	Continued From page 14 including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; and - ensuring that nurses and licensed health professionals have current and valid licenses to practice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving, hand hygiene, and catheter care for	0 510			

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0 510	Continued From page 15 one of two employees (housing manager (HM)-A). In addition, the licensee failed to provide the surveyor with their infection control program or policies. 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 December 1, 2025, at 12:01 p.m., the surveyor requested the licensee's infection control program and policies. HM-A stated they did have one in place and would send it via email to the surveyor. On December 1, 2025, at 2:42 p.m., HM-A sent an email to the surveyor with the subject line "Infection Control Policies" with an attachment titled "facility staffing plan". On December 2, 2025, at 8:34 a.m., the surveyor observed HM-A put on a clean set of gloves without completing hand hygiene. HM-A then began preparing morning medications for R1. At 9:14 a.m., the surveyor observed HM-A administer medications to R1, and then without completing hand hygiene or changing gloves began preparing coffee for R1. At 9:16 a.m., without completing hand hygiene or changing gloves, the surveyor observed HM-A cleaning dishes at sink. After completing dishes, HM-A removed gloves, and did not complete hand	0 510			

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0 510	Continued From page 16 hygiene. At 9:21 a.m., HM-A put on gloves without completing hand hygiene and began preparing morning medications for R2. On December 3, 2025, at 12:49 a.m., HM-A stated they were trained to complete hand hygiene between glove changes, and that they had forgotten to do so. On December 4, 2025, at 12:11 p.m., clinical nurse supervisor (CNS)-B stated staff were expected to wash their hands in between glove changes, and from resident to resident. On December 2, 2025, at 11:19 a.m., in response to request for the licensee's policies and procedures made on December 1, 2025, at 11:56 a.m., housing manager (HM)-A provided the surveyor with a file titled "Our forms". The provided information lacked required policies and procedures related to infection control. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650			

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0 650	Continued From page 17 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 employee records contained the required content for one of two employees (housing manager (HM)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: HM-A was hired June 2, 2025, to provide assisted living services and administrative oversight. On December 2, 2025, from 8:31 a.m., to 9:23 a.m., the surveyor observed HM-A provide morning medications for multiple residents.	0 650			

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0 650	Continued From page 18 HM-A's employee record lacked documentation of the following required training topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. On December 3, 2025, at 12:54 p.m., after the surveyor completed a line-by-line review of all	0 650			

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0 650	Continued From page 19 previously listed missing training topics with HM-A, HM-A attested that they recalled receiving training on all training topics listed above. HM-A stated they did not recall being trained on the following: - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - standby assistance techniques and how to perform them; - preparation of modified diets as ordered by a licensed health professional; - safe transfer techniques and ambulation, and; - range of motioning and positioning. HM-A's employee record lacked documentation of the following required competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them. On December 3, 2025, at 12:54 p.m., HM-A stated they recalled receiving training on the knowledge of body functions as well as training on physical, emotional, cognitive, and developmental needs. HM-A stated they did not recall receiving training or competencies on safe transfer and ambulation or range of motion and positioning. The licensee's Personnel Records policy dated June 1, 2025, indicated documentation of orientation would be included in the personnel record.	0 650			

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0 650	Continued From page 20 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of two employees (house manager (HM)-A, clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660			

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0 660	Continued From page 21 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: The licensee's current TB risk assessment completed June 15, 2025, indicated a low risk level. HM-A HM-A was hired June 2, 2025, to provide assisted living services and administrative oversight. HM-A's employee record contained a TB symptom screening dated June 2, 2025. HM-A's record contained a QuantiFERON-TB Gold Plus test with negative results and a collection date of October 27, 2022. HM-A's record contained no other documentation of a TB test. CNS-B CNS-B was hired June 15, 2025, to provide assisted living services and clinical oversight. CNS-B's employee record contained a TB symptom screening dated June 9, 2025. CNS-B's record contained a QuantiFERON-TB Gold Plus test with negative results and a collection date of June 21, 2024. CNS-B's record contained no other documentation of a TB test. On December 4, 2025, at 1:52 p.m., CNS-B stated they were under the assumption the QuantiFERON-TB test was good forever, and was not aware old results could not be used at	0 660			

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0 660	Continued From page 22 the time of hire. The licensee's Tuberculosis Screening/Prevention policy dated June 1, 2025, will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The CDC's Morbidity and Mortality Weekly Report, Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, dated December 30, 2005, indicated that all HCW's (health care workers) should receive baseline TB screening upon hire, using two-step TST or a single BAMT (Blood Assay for Mycobacterium tuberculosis) to test for infection with M. tuberculosis. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (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			

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0 680	Continued From page 23	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post the emergency plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 680			

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0 680	Continued From page 24 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 December 1, 2025, at 12:37 p.m., housing manager (HM)-A provided the surveyor with a copy of an un-customized EPP. On December 2, 2025, at 2:44 p.m., HM-A provided the surveyor with a customized copy of the licensee's EPP and explained the document reviewed yesterday was a sample copy provided by the company the licensee purchased their policy manual from. HM-A stated the customized EPP was offsite yesterday. On December 2, 2025, at 2:55 p.m., HM-A stated they had worked with home care consultant on customizing the EPP. The licensee's EPP dated June 15, 2025, lacked evidence of the following required content: - arrangement with other facilities; - emergency officials contact information; and - primary/alternate means for communication. The licensee's Emergency Preparedness dated June 1, 2025, 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.	0 680			

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0 680	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41247	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA HEALTHCARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 5126 LONG LAKE ROAD MOUNDS VIEW, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 26 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 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 12-3-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
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 27 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 one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12-3-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=I	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800			

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0 800	Continued From page 28 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation. This had the potential to directly affect all residents, staff, and visitors. 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: On December 1, 2025, from 11:11 a.m., to 11:44 a.m., the surveyor toured the facility with house manager (HM)-A, and the surveyor observed multiple electric space heaters in use throughout. On December 1, 2025, at 11:27 a.m., HM-A stated the facility furnace was broken and they were utilizing electric space heaters for temporary heat. HM-A stated they had someone coming out soon for repair. On December 2, 2025, at 1:12 p.m., the surveyor observed the facility thermostat on the upper level read 69 degrees Fahrenheit (F). The temperature in the lower basement level was unknown.	0 800			

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0 800	Continued From page 29 On December 2, 2025, at 1:31 p.m., during an interview in the basement room of R2, R2 stated the furnace had been out of commission since prior to November 27, 2025. R2 stated they had been utilizing space heaters for warmth because it was cold, but they were also concerned about the fire risk with use of the space heaters as they had recently been affected by a fire at a different facility. On December 2, 2025, at 1:54 p.m., the surveyor utilized the licensee's infrared temperature sensor to obtain surface temperatures throughout the facility. In the upstairs of the facility, the surveyor was able to obtain temperatures of 70 degrees F. In the bedroom of R2, the surveyor was able to obtain temperatures ranging from 65-67 degrees F. Within the basement near the exterior windows, the surveyor obtained surface temperatures of the wall and table near ranging from 59-63 degrees F. The licensee's Emergency Preparedness Plan (EPP) dated June 15, 2025, named HM-A as the licensee's incident commander (IC). The EPP indicated the IC would determine when and if the residents need to be evacuated to another location due to a lack of heat. The EPP did not dictate a temperature range in which an evacuation would be warranted. Additionally, the licensee's EPP indicated the registered nurse (RN) was responsible for the initial evaluation of residents during an emergency, and the RN would work with the IC for arranging emergency transportation for residents as needed. On December 2, 2025, at 2:33 p.m., the National Weather Service website indicated the average high temperature from Thanksgiving (November	0 800			

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0 800	Continued From page 30 27, 2025) to date was 24 degrees F. On December 2, 2025, at 2:35 p.m., the National Weather Service website indicated the outside temperature in the licensee's city was 21 degrees F. The website indicated the low for the nighttime hours was expected to be 13 degrees F. The National Weather Service website also indicated the forecast for the next three days was as follows: - Wednesday, December 3, 2025: High of 16 degrees F, Low of -7 degrees F. - Thursday, December 4, 2025: High of 16 degrees F, Low of 12 degrees F. - Friday, December 5, 2025: High of 26 degrees F, Low of 9 degrees F. On December 2, 2025, at 3:22 p.m., HM-A stated that if the outdoor temperatures dropped to below zero degrees F, they would consider evacuation to a different facility. HM-A stated they had no current plan in place to evacuate residents. On December 2, 2025, at 3:10 p.m., HM-A stated they had been in contact twice with their landlord, once to notify them of the broken furnace on November 27, 2025, and again on November 28, 2025, when the repair had not been completed. HM-A stated they had made several attempts since then to contact them and was only able to reach them again today. The licensee had no documentation of their attempts to reach their landlord after November 28, 2025, or of any plan to rectify the broken furnace. On December 2, 2025, at 4:30 p.m., the surveyor observed a furnace repair person arrive and begin working on the furnace. The repair person removed a furnace filter that was black in color and explained to HM-A that the dirty filter was the	0 800			

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0 800	Continued From page 31 cause of the non-functioning furnace. Minnesota Statute 144G.45 Minimum Site, Physical Environment, and Fire Safety Requirements Subd. 3.Local laws apply indicates, "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." Minnesota Statute 504B.161 Covenants of Landlord or Licensors Subd. 1.Requirements (5) indicates, "to equip or furnish heat at a minimum temperature of 68 degrees Fahrenheit in all places intended for habitation including kitchens and bathrooms from October 1 through April 30, unless a utility company requires and instructs the heat to be reduced." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810			

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0 810	Continued From page 32 (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 33 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 12-3-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			
01290 SS=I	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 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in	01290			

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01290	Continued From page 34 affiliation with the assisted living license for two of two employees (house manager (HM)-A, clinical nurse supervisor (CNS)-B). 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 HM-A was hired June 10, 2025, to provide administrative and assisted living services. CNS-B was hired on June 15, 2025, to provide clinical oversight and assisted living services. On December 2, 2025, the Minnesota Board of Nursing website indicated CNS-B was licensed as a registered nurse on June 23, 2004. HM-A and CNS-B's records both contained background studies with clearance dates of December 2, 2025, completed during the survey. HM-A and CNS-B's records lacked evidence the licensee submitted a background study prior to the start of the survey. On December 2, 2025, at 1:16 p.m., HM-A stated that they, and CNS-B did not have a background study in place prior to the start of survey. HM-A stated they were responsible for maintaining the licensee's background study roster. On December 2, 2025, at 4:07 p.m., HM-A stated they thought the background checks were run	01290			

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01290	Continued From page 35 already and thought they had done it. The licensee's 2.34 background checks policy dated June 1, 2025, indicated the licensee would complete a background study on all employees who will have independent, unsupervised contact with tenants or clients. No employee may have independent direct contact with any tenants or clients until acceptable result of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by:	01330			

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01330	Continued From page 36 Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel, housing manager (HM)-A. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: HM-A was hired June 2, 2025, to provide assisted living services and administrative oversight. On December 2, 2025, from 8:31 a.m., to 9:23 a.m., the surveyor observed HM-A provide morning medications for multiple residents. HM-A's employee record lacked documentation of the following required training topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to	01330			

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01330	Continued From page 37 perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. On December 3, 2025, at 12:54 p.m., after the surveyor completed a line-by-line review of all previously listed missing training topics with HM-A, HM-A attested that they recalled receiving training on all training topics listed above. HM-A stated they did not recall being trained on the following: - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - standby assistance techniques and how to perform them; - preparation of modified diets as ordered by a licensed health professional; - safe transfer techniques and ambulation, and; - range of motioning and positioning. On December 4, 2025, at 1:50 p.m., licensed assisted living director (LALD)-C stated they were	01330			

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01330	Continued From page 38 aware the trainings needed to be completed and recalled going over many of the topics via presentation. The licensee's 5.02 Competency Training Evaluations policy dated June 1, 2025, indicated the following: "Training and competency evaluation for unlicensed personnel providing assisted living services must include: - Observing, reporting, and documenting resident status - Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel - Reading and recording temperature, pulse, and respirations of the resident - Recognizing physical, emotional, cognitive, and developmental needs of the resident - Safe transfer techniques and ambulation - Range of motioning and positioning - Administering medications or treatments as required". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470			

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01470	Continued From page 39 (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 40 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (housing manager (HM)-A and clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HM-A HM-A was hired June 2, 2025, to provide assisted living services and administrative oversight. On December 2, 2025, from 8:31 a.m., to 9:23 a.m., the surveyor observed HM-A provide morning medications for multiple residents.	01470			

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01470	Continued From page 41 HM-A's employee record lacked documentation of the following required orientation topics: - overview of assisted living statutes; - reporting maltreatment of vulnerable adults or minors; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license, and; - principles of person-centered planning/service delivery. On December 3, 2025, at 12:25 p.m., HM-A stated they recalled receiving training on reporting maltreatment of vulnerable adults or minors. HM-A stated they did not recall receiving orientation on consumer advocacy and statute training. HM-A went on to say they thought they had received statute training and thought it was included in their dementia care training. CNS-B CNS-B was hired June 15, 2025, to provide assisted living services and clinical oversight. CNS-B's employee record lacked documentation of the following required orientation topics: - overview of assisted living statutes; - reporting maltreatment of vulnerable adults or minors; - handing of resident complaints, reporting of complaints, where to report; - review of types of assisted living services the employee will provide and provider's scope of license, and; - principles of person-centered planning/service delivery.	01470			

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01470	Continued From page 42 On December 4, 2025, at 12:17 p.m., CNS-B stated they did not understand why they need to complete the same orientation over and over at every facility. The licensee's Personnel Records policy dated June 1, 2025, indicated documentation of orientation would be included in the personnel record. The licensee provided the surveyor with a document titled "Minnesota Healthcare Services LLC Orientation Checklist". The form indicated staff orientation would include the following: Introduction to Agency Mission, Organizational Chart and Structure - Assisted Living Services; - Overview of Assisted Living Statute; - Assisted Living Bill of Rights; - Handling/Reporting Resident Complaints; - Consumer Advocacy Services; - Handling of Emergencies/Emergency Services; - Fire Safety and Evacuation; - Reporting Maltreatment of Vulnerable Adults; - Confidentiality Policy; - Infection Control, including TB Prevention; - Personnel Policies; - Emergency Preparedness; - Resident Care and Documentation Policies; - Skills Competency Evaluation, and; - Medication Competency Evaluation. - HIPAA - Dementia (8 hours required within 160 hours for direct caregivers) - Person-Centered Care No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01470			

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01470	Continued From page 43 (21) days	01470			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed 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	01530			

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01530	Continued From page 44 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 staff received eight hours of initial dementia care training within 160 working hours of employment for direct care staff as required for one of two employees (housing manager (HM)-A). Additionally, the licensee failed to ensure direct care staff completed two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for one of two employees (HM-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: HM-A was hired June 2, 2025, to provide assisted living services and administrative over-site. On December 2, 2025, from 8:31 a.m., to 9:23 a.m., the surveyor observed HM-A provide morning medications for multiple residents. HM-A's employee record contained	01530			

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01530	Continued From page 45 documentation of dementia care training with the most recent training occurring on November 1, 2022. HM-A's record lacked documentation of the required initial 8 hours of dementia care training within 120 hours and initial 2 hours of mental illness and de-escalation training within 120 hours occurring within 18 months prior to their hire date. On December 3, 2025, at 1:10 p.m., HM-A stated they recalled receiving mental health training at their time of hire. HM-A stated the content covered topics such as depression, and de-escalation. HM-A stated the training was completed in around 30-minutes. On December 4, 2025, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated they were aware of the dementia and mental health training requirements. CNS-B stated they were responsible for completing competency testing and that HM-A was responsible for the assigning of training topics. On December 4, 2025, at 1:55 p.m., licensed assisted living director (LALD)-C stated they were not aware of the new mental health training requirements, but would ensure staff completed required trainings to bring the licensee up to compliance. The licensee's Personnel Records policy dated June 1, 2025, indicated documentation of orientation would be included in the personnel record. The licensee lacked further policies or procedures defining the required contents of a dementia care and mental health training program.	01530			

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01530	Continued From page 46 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment prior to the execution of the assisted living contract/providing services for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01610			

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01610	Continued From page 47 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on June 9, 2025, to receive assisted living services. R1's diagnoses included type 2 diabetes mellitus with diabetic nephropathy, alcohol induced acute pancreatitis without necrosis or infection, and anemia. R1's Service Plan dated June 9, 2025, indicated R1 received assistance with dressing, feeding/eating, oral hygiene, toileting, standby assistance, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers and mobility, treatments and therapies, personal laundry, housekeeping, and safety checks. R1's record contained an assisted living contract with a signature date of June 9, 2025. R1's initial assessment was dated June 11, 2025, which indicated that two days had passed since admission to the licensee. On December 4, 2025, at 12:24 p.m., clinical nurse supervisor (CNS)-B stated they were aware assessments needed to be completed prior to the signing of an assisted living contract. CNS-B stated they thought an assessment had been completed prior to the signing of the assisted living contract, but there was an error in	01610			

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01610	Continued From page 48 transferring between paper records and electronic records. On December 1, 2025, at 11:56 a.m., the surveyor requested policies related to assessments via email. On December 2, 2025, at 11:19 a.m., housing manager (HM)-A provided the surveyor with a document via email titled "Our Forms Manual". On December 3, 2025, at 11:27 a.m., HM-A stated the document titled "Our Forms Manual" contained requested polices related to assessments. The document lacked information related to assessments. The licensee lacked a policy or procedure related to assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01610			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic	01620			

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01620	Continued From page 49 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. This MN Requirement is not met as evidenced by:	01620			

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01620	Continued From page 50 Based on interview and record review, the licensee failed to ensure a licensed registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for one of two residents (R1) residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on June 9, 2025, to receive assisted living services. R1's primary diagnoses included type 2 diabetes mellitus with diabetic nephropathy, alcohol induced acute pancreatitis without necrosis or infection, and anemia. R1's Service Plan dated June 9, 2025, indicated R1 received assistance with dressing, feeding/eating, oral hygiene, toileting, standby assistance, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers and mobility, treatments and therapies, personal laundry, housekeeping, and safety checks. R1's record contained a 14-day assessment dated June 23, 2025, and a 90-day assessment dated September 24, 2025, which indicated that 93 days had passed between assessments.	01620			

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01620	Continued From page 51 On December 4, 2025, at 12:26 p.m., clinical nurse supervisor (CNS)-B stated the lapse in assessment timing was due to the resident being unavailable and out of the building at the time of the assessment. CNS-B stated there was no documentation in R1's record to show this as being the reason for the delayed assessment. CNS-B stated the assessment could have been done remotely, but that they had wanted to ensure the assessment was completed in person. On December 1, 2025, at 11:56 a.m., the surveyor requested policies related to assessments via email. On December 2, 2025, at 11:19 a.m., housing manager (HM)-A provided the surveyor with a document via email titled "Our Forms Manual". On December 3, 2025, at 11:27 a.m., HM-A stated the document titled "Our Forms Manual" contained requested polices related to assessments. The document lacked information related to assessments. The licensee lacked a policy or procedure related to assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01730 SS=D	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 52 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 53 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 was admitted on June 9, 2025, to receive assisted living services. R2's diagnoses included scoliosis, anxiety disorder, essential hypertension, and chronic pain. R2's service plan dated June 9, 2025, indicated R2 received assisted living services to include assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, medication reminders, treatments and exercise, medication administration, hands on assist with transfers and mobility, treatments and therapies, eating assistance, and personal laundry.	01730			

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01730	Continued From page 54 R2's Individualized Medication Management Plan dated September 8, 2025, lacked the following required information: - medication management services provided by nurse and unlicensed personnel (ULP) (included PRN); - type of medication storage system, based on resident's needs; - specific written instructions for resident's medication administration; - medication management tasks that may be delegated to ULPs, and; - procedures for staff to notify an RN when problems arose. On December 4, 2025, at 12:29 p.m., clinical nurse supervisor (CNS)-B stated they thought they had finished the documentation for R2 upon admission and thought the documentation may have been misplaced. The licensee's Service Plan for Medication Management policy dated June 1, 2025, indicated the registered nurse is responsible for preparing and documenting the Medication Management Plan. Additionally, the policy indicated the Medication Management Plan will include the following provisions: "a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the resident assessment* and addressing i. Resident preference ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for medication reconciliation* e. Identification of person(s) responsible for monitoring medication supplies and ensuring	01730			

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01730	Continued From page 55 refills are ordered/timely f. Description of medication management tasks to be delegated to unlicensed personnel g. Plans for staff notifying the licensed health professional when/if a problem with medication management services arises h. Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2). 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	01820			

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01820	Continued From page 56 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: R2 was admitted on June 9, 2025, to receive assisted living services. R2's diagnoses included scoliosis, anxiety disorder, essential hypertension, and chronic pain. R2's service plan dated June 9, 2025, indicated R2 received assisted living services to include assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, medication reminders, treatments and exercise, medications administration, hands on assist with transfers and mobility, treatments and therapies, eating assistance, and personal laundry. R2's medication administration record (MAR) for the month of November 2025, indicated R2 was receiving the following medications: - Acetaminophen 500 mg, take 2 tablets every 6 hours by oral route as needed, for 10 days, for chronic pain - or Every 8 hours - Buprenorphine HCl, take 1/2 tablet (4 mg) sublingually three times daily - Cetirizine Hydrochloride, take 1 tablet by mouth daily by mouth 1 x a day - Clonidine HCL 0.1 mg, take 1 tablet by mouth three times daily as needed for anxiety or sweating - Up To 3 times per day - Cyclobenzaprine Hydrochloride 5 mg, take 1tablet by mouth 2 times daily as needed for muscle spasm/myalgias - Up To 2 times per day - Diclofenac Sodium 3 %, Apply to the back for	01820			

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01820	Continued From page 57 pain as ordered topical 1 x a day - Diclofenac Sodium 3 %, Apply 1 gram to affected areas of neck, back, hip three times daily as needed - Up To 3 times per day - Duloxetine HCL 60 Mg Cap Dr, Take 1 capsule (60 mg) by mouth in the morning daily. by mouth 1 x a day - Duloxetine HCL 30 Mg Cap, Take 1 capsule (30mg) by mouth at bedtime daily. by mouth 1 x a day - Folic Acid 1mg, Take 1 tablet by mouth daily by mouth 1 x a day - Gabapentin 600 mg, Take 2 tablets by mouth three times daily by mouth 3 x a day - Lisinopril 10mg, Take One tablet by mouth daily for blood pressure by mouth 1 x a day - Meclizine HCl 25mg Chewable Tablets, take 1 tablet by mouth three times a day as needed for dizziness - or Every 6 hours - Metoprolol 25 mg, Take 0.5 tablets by mouth 2 times daily by mouth 2 x a day - Naloxone Hydrochloride 4 mg, 4/0.1 mg/ml- Use as directed as needed for accidental overdose, then call 911 - Up To 1 time per day - Ondansetron Hydrochloride 4 mg, take 1 tablet by mouth three times daily as needed for nausea - Up To 3 times per day - Pantoprazole Sodium 40 mg, Take 1 tablet by mouth one time a day. Do not crush by mouth by mouth 1 x a day - Propranolol 10 mg, take 1 tablet by mouth two times daily as needed for tremor - or Every 8 hours - Thiamine Hydrochloride 100 mg, Take 1 tablet by mouth once daily by mouth 1 x a day - Vitamin B-1 100 Mg Tabs, take one capsule by mouth daily by mouth 1 x a day - Vitamin D 2000 units, Take 1 capsule by mouth daily by mouth 1 x a day - Diclofenac Sodium 3 %, Apply to the back for	01820			

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01820	Continued From page 58 pain as ordered topical 1 x a day R2's record contained physician orders which included the following medications found on R2's MAR: - Meclizine 25mg - Propranolol 10mg tab - Duloxetine 60mg cap delayed release - Diclofenac 3% - Tylenol 500mg, 2 tablets every 8 hours as needed for pain - Naloxone 4mg/actuation R2's record lacked any additional documentation of signed physician orders. On December 3, 2025, at 9:57 a.m., the surveyor requested a copy of R2's signed physician orders via email. On December 4, 2025, at 9:44 a.m., the surveyor again requested a copy of R2's signed physician orders and provided a deadline of 10:30 a.m., December 4, 2025. On December 4, 2025, at 10:55 a.m. the licensee responded via email to the request for signed physician orders stating "We are still waiting for her doctor's office to fax those documents. We did receive it initially, but we can't locate the paper we received before, so we requested another copy from them." The licensee's Prescriber's Orders policy dated June 1, 2025, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications.	01820			

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01820	Continued From page 59 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 1, 2025, at 11:11 a.m., during a tour of the facility, the surveyor observed the following unsecured medications in the licensee's kitchen refrigerator:	01880			

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01880	Continued From page 60 - A box of Lantus Solostar 100units/ml insulin pens belonging to R1, and; - A box Insulin Aspart 100units/ml insulin pens belonging to R1. R1 was admitted to the licensee on June 9, 2025, to receive assisted living services. R1's diagnoses included type 2 diabetes mellitus with diabetic nephropathy, alcohol induced acute pancreatitis without necrosis or infection, and anemia. R1's Service Plan dated June 9, 2025, indicated R1 received assistance with dressing, feeding/eating, oral hygiene, toileting, standby assistance, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers and mobility, treatments and therapies, personal laundry, housekeeping, and safety checks. The licensee's facility was a residential five-bedroom home. The kitchen was located on the main living area of the facility directly adjacent to a dining area, living room, and front door. The kitchen was easily accessible by residents and individuals not authorized to have access to resident medications. On December 3, 2025, at 1:12 p.m., housing manager (HM)-A stated when the pharmacy delivers R1's insulin they instruct the facility to refrigerate the medications. HM-A stated the residents within the facility do not typically access the kitchen refrigerator. On December 4, 2025, at 12:35 p.m., clinical nurse supervisor (CNS)-B stated around June 2025, when R1 was admitted, they had advised	01880			

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01880	Continued From page 61 HM-A and licensed assisted living director (LALD)-C to purchase a separate refrigerator for the storage of medications. CNS-B stated they thought this was in the process of being implemented. The licensee's Storage/Control of Medications policy dated June 1, 2025, indicated when the licensee is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were kept in the original container dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	01890			

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01890	Continued From page 62 drug. In addition, the licensee failed to dispose of expired medications. This had a potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On December 2, 2025, at 9:04 a.m., during an audit of the licensee's medication storage, the surveyor observed the following: Expired Medications: - Gabapentin 800mg tablets belonging to R1 with an expiration date of August 9, 2025; - Acetaminophen Extra Strength 500mg tablet belonging to R1 with an expiration date August 5, 2025; - Kao pectate with no resident label with an expiration date of March 2025, and; - Meclizine HCL 25mg tab belonging to R2 with an expiration date of July 25, 2025. Unidentified Medications: - One large white oval shaped tablet in medication drawer belonging to R1. On December 3, 2025, at 1:13 p.m., HM-A stated they were responsible for auditing the medication storage cart and had been trained to notify the nurse if they found anything loose or expired. HM-A stated they usually checked over the	01890			

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01890	Continued From page 63 medication cart every three to six months. On December 4, 2025, at 12:38 p.m., clinical nurse supervisor (CNS)-B stated staff are trained to notify the nurse if an unidentified medication is found so that an incident report may be completed, and the medication can be appropriately disposed of. The licensee's Storage/Control of Medications policy dated June 1, 2025, indicated prescription drugs, prior to being set up for immediate or later administration, must be kept in the original containers in which they were dispensed by the pharmacy bearing the original prescription label with legible information and the nurse is responsible for checking expiration dates. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced	01960			

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01960	Continued From page 64 by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were documented accurately in the record for one of one resident (R1) recieving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 to the licensee on June 9, 2025, to receive assisted living services. R1's diagnoses included type 2 diabetes mellitus with diabetic nephropathy, alcohol induced acute pancreatitis without necrosis or infection, and anemia. R1's Service Plan dated June 9, 2025, indicated R1 received assistance with dressing, feeding/eating, oral hygiene, toileting, standby assistance, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers and mobility, treatments and therapies, personal laundry, housekeeping, and safety checks. R1's record contained physician orders dated August 14, 2025, with the following: - CONTOUR NEXT TEST in vitro test strips, USE AS DIRECTED 4 TIMES A DAY;	01960			

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01960	Continued From page 65 - insulin pen needle (B-D U/F PEN NEEDLE) 31g x 8 mm, USE TO INJECT INSULIN FOUR TIMES A DAY; - insulin ASPART (NOVOLOG) 100 units/ml subcutaneous FlexPen, inject 4 UNITS subcutaneously daily as needed (blood sugar >300), and; - Lantus SoloStar 100 UNIT/ML SoloStar pen, inject 0.32 ml (32 UNITS) subcutaneously daily in the afternoon. R1's record contained no documentation of R1's obtained blood glucose numbers. On December 3, 2025, at 11:42 a.m., housing manager (HM)-A stated they did not have a place to document blood glucose results for R1. HM-A stated when a blood glucose over 300 is obtained, they contact the nurse. On December 4, 2025, at 12:41 p.m., clinical nurse supervisor (CNS)-B stated there was a paper form developed at the time of R1's admission, but was unsure of where this document was or what had happened to it. CNS-B stated that once ordered tasks are completed, they should be documented as being completed. The licensee's Treatment and Therapy Management policy dated June 1, 2025, indicated each staff member who administers a treatment or therapy is responsible for documenting in the clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			

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02320	Continued From page 66	02320			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication administration for all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 to the licensee on June 9, 2025, to receive assisted living services. R1's diagnoses included type 2 diabetes mellitus with diabetic nephropathy, alcohol induced acute pancreatitis without necrosis or infection and Anemia.	02320			

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02320	Continued From page 67 R1's Service Plan dated June 9, 2025, indicated R1 received assistance with dressing, feeding/eating, oral hygiene, toileting, standby assistance, medication reminders, treatments and exercises, medication administration, hands on assistance with transfers and mobility, treatments and therapies, personal laundry, housekeeping, and safety checks. On December 2, 2025, at 8:33 a.m. the surveyor observed housing manager (HM)-A set up R1's morning medications. The surveyor observed HM-A retrieve R1's medications from the locked medication cabinet. R1's medications came pre-setup by the pharmacy in comingled medication cups, which contained the following medications: - Aspirin 81mg; - Famotidine 20mg; - Vitamin D3 1000iu; - Gabapentin 800mg; - Four Metformin 500mg tablets. On December 2, 2025, at 8:36 a.m., after retrieving R1's morning medications, HM-A brought medications to R1 without first verifying the medications with the medication administration record (MAR). The surveyor intervened and directed HM-A to verify the medications prior to administration. On December 2, 2025, at 8:38 a.m., the surveyor requested HM-A to demonstrate the process of verifying medications. HM-A was unable to locate R1's electronic medications administration record (EMAR) on the licensee's electronic medical record (EMR). On December 2, 2025, at 8:41 a.m., HM-A stated	02320			

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NAME OF PROVIDER OR SUPPLIER MINNESOTA HEALTHCARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 5126 LONG LAKE ROAD MOUNDS VIEW, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 68 that because all medications were set up by the pharmacy, they were under the assumption medications did not need to be verified prior to administration, and this was the practice they had adopted for all residents. Additionally, HM-A stated they were under the assumption that the licensee's EMAR would automatically document medications as being administered and was not aware they needed to do anything differently. On December 2, 2025, at 8:49 a.m., HM-A was able to locate R1's EMAR. HM-A stated they had never seen or used it. On December 2, 2025, at 8:52 a.m., HM-A stated they were trained and competency tested on medication administration by a nurse that had worked for the licensee prior to clinical nurse supervisor (CNS)-B. HM-A's employee record contained documentation of medication administration training. On December 2, 2025, at 8:57 a.m., CNS-B stated it would be safe to say that medications were not being documented as having been administered. Additionally, CNS-B stated staff should be verifying medication prior to administration but were trained initially by the licensee's previous nurse. On December 2, 2025, at 9:14 a.m., HM-A administered morning medications to R1 after receiving verification and direction from CNS-B. On December 2, 2025, at 9:21 a.m., the surveyor observed CNS-B providing hands on directions to HM-A on how to document morning medications using the licensee's EMAR. The licensee's Medication Administration policy	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41247	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA HEALTHCARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 5126 LONG LAKE ROAD MOUNDS VIEW, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
02320	Continued From page 69 dated June 1, 2025, indicated the registered nurse may delegate medication administration to an unlicensed staff member after having passed a competency evaluation. Additionally, all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: "a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effects g. Resident allergies to medications" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



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

Minnesota Healthcare Services
5126 Long Lake Road
Mounds View, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 41247

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

Inspection Info

Report Number: F1025251226
Inspection Type: Full - Single
Date: 12/2/2025 Time: 3:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery:

New Order: 2-100 Supervision

2-102.12DMN *Priority Level: Priority 3 CFP#: 2*

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: Course certificate from Dec posted at establishment. When the CFPM certificate is received, post.

For online application information, please see <https://www.health.state.mn.us/communities/environment/food/cfpm/index.html>

Comply By: 12/2/2025 Originally Issued On: 12/2/2025

New Order: 4-100 Equipment Construction Materials

4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

COMMENT: Remove ceramic pan with scratched coating, voluntarily discarded. Suggest replacing with a stainless steel pan without coating.

Comply By: Complied On Site Originally Issued On: 12/2/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: Provide a food thermometer for the establishment

Comply By: 12/5/2025 Originally Issued On: 12/2/2025

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT: Provide a means of testing the internal temperature of the sanitize cycle on the dishwasher

Comply By: 12/5/2025 Originally Issued On: 12/2/2025

Food & Beverage General Comment

Discussed items for correct, provided email, send confirmation (photos, receipts, etc) of corrections to email by Friday Dec 5

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 F1025251226 from 12/2/2025



Establishment Representative

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
Minnesota Healthcare Services	Report Number: F1025251226
Mounds View	Inspection Type: Full
County/Group: Ramsey County	Date: 12/2/2025
	Time: 3:00 PM

Food Temperature: **Product/Item/Unit:** Dressing; **Temperature Process:** Cold holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41247015-0	Date: 12/3/2025
Facility Name: MINNESOTA HEALTHCARE SERVICES	
Facility Address: 5126 Long Lake Rd, Mounds View, Minnesota 55112	

☒ 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: The portable fire extinguishers throughout the facility lacked records to show monthly and annual servicing was completed. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly and annually replaced with a new extinguisher or serviced annually by a certified technician.

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

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

Comments: House manager (HM)-A tested the smoke alarms throughout the facility. The smoke alarms throughout the facility were not interconnected, and all smoke alarms only sounded locally.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: HM-A stated that staff training was done in Educare and not on the licensee's written FSEP. No additional training documentation was provided.

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

Comments: HM-A stated they do not have a resident evacuation training program. No documentation was provided.

3. 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: Licensee's evacuation drill log indicated an evacuation drill was performed June 15, 2025. No additional evacuation drill documentation was provided.