DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 16, 2026

Licensee
Noble Residential Living
179 Pottok Lane
Shakopee, MN 55379

RE: Project Number(s) SL38348016

Dear Licensee:

On December 31, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 29, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 29, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 29, 2025, found not corrected at the time of the December 31, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0550-Resident Grievances; Reporting Maltreatment-144g.41 Subd. 7
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
1320-Unlicensed Personnel-144g.60 Subd. 4 (a) - $500.00
1330-Unlicensed Personnel-144g.60 Subd. 4 (b) - $500.00
1470-Content Of Required Orientation-144g.63 Subd. 2 - $500.00
1500-Required Annual Training-144g.63 Subd. 5 - $500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - $500.00

The details of the violations noted at the time of this follow-up survey completed on December 31, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

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

the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38348	A. BUILDING: _____ B. WING _____	R 12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL38348016-1 On December 29, 2025, through December 31, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 29, 2025. At the time of the survey, there were four residents; four receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued: 0550, 0680, 1320, 1330, 1470, 1500, 1650, and 1760.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 550} SS=C	144G.41 Subd. 7 Resident grievances; reporting maltreatment	{0 550}		

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{0 550}	Continued From page 1 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed have all the required contact in the posted grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 29, 2025, at 3:45 p.m., the surveyor observed the grievance posting. The posting included the licensed assisted living director (LALD) and their phone number, but did	{0 550}		

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{0 550}	Continued From page 2 not include the email contact information as required. The licensee's undated, Grievance/Complaint Concerns document posted indicated "You can bring any grievances, complaints or concerns to the Director" and included the LALD name and phone number. The document did not contain the LALD's email contact information as required. On December 29, 2025 at 3:45 p.m., unlicensed personnel (ULP)-D stated she was unaware it needed to be on the grievance posting and she would add it. No further information was provided.	{0 550}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	{0 680}		

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{0 680}	Continued From page 3 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of 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: The licensee provided a three ring binder labeled Emergency Preparedness Manual. The undated, EPP lacked evidence of the following required content: - policy to address use of volunteers including the process/role for integration; - contact information for State Licensing and Certification Agency; - communication plan that included: and - a means to provide information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or	{0 680}		

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{0 680}	Continued From page 4 designee. On December 31, 2025, at 12:00 p.m., unlicensed personnel (ULP)-D stated the emergency preparedness plan did not include the above noted content and it would need to be added. No additional information was provided.	{0 680}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice	{0 810}		

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{0 810}	Continued From page 5 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:	{0 810}		
{01320} SS=E	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as	{01320}	Not reviewed during this survey.	

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{01320}	Continued From page 6 required prior to providing direct care for three of three employees (unlicensed personnel (ULP)-D, ULP-G, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. During the initial survey on October 27, 2025, at 11:13 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's record lacked evidence of training in the following required topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (7) standby assistance techniques and how to	{01320}		

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{01320}	Continued From page 7 perform them; (11) 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; (13) understanding appropriate boundaries between staff and residents and the resident's family; and (15) awareness of commonly used health technology equipment and assistive devices. ULP-G ULP-G was hired on January 29, 2023, and provided direct care services to the facility's residents. On December 30, 2025, at 9:20 a.m., the surveyor observed ULP-G administering medications to the residents. ULP-G's record lacked evidence of training in the following required topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	{01320}		

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{01320}	Continued From page 8 cultural background, and family; (13) understanding appropriate boundaries between staff and residents and the resident's family; and (15) awareness of commonly used health technology equipment and assistive devices. ULP-I ULP-I was hired on December 23, 2025, and provided direct care services to the facility's residents. On December 29, 2025, at 4:00 p.m., the surveyor observed ULP-I administering medications to the residents. ULP-I's record lacked evidence of training in the following required topics: (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting. On December 31, 2025, at 11:25 a.m., ULP-D stated some of the training had been assigned in the electronic training system, but staff had not yet completed it. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2024, included 5. Training and competency evaluations for all ULP's will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition	{01320}		

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{01320}	Continued From page 9 to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) 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 l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices. No further information was provided.	{01320}		
{01330} SS=E	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:	{01330}		

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{01330}	Continued From page 10 (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: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for three of three employees (unlicensed personnel (ULP)-D, ULP-G, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	{01330}		

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{01330}	Continued From page 11 ULP-D ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. During the initial survey on October 27, 2025, at 11:13 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's record lacked evidence of training in the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. ULP-G ULP-G was hired on January 29, 2023, and provided direct care services to the facility's residents. On December 30, 2025, at 9:20 a.m., the surveyor observed ULP-G administering medications to the residents. ULP-G's record lacked evidence of training in the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and	{01330}		

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{01330}	Continued From page 12 changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. ULP-I ULP-I was hired on December 23, 2025, and provided direct care services to the facility's residents. On December 29, 2025, at 4:00 p.m., the surveyor observed ULP-I administering medications to the residents. ULP-I's record lacked evidence of training in the following required topics: (3) reading and recording temperature, pulse, and respirations of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. On December 31, 2025, at 11:25 a.m. ULP-D stated some of the training had been assigned in the electronic training system but staff had not yet completed it. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2024, included training and competency evaluation for unlicensed personnel providing assisted living	{01330}		

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{01330}	Continued From page 13 services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required No further information was provided.	{01330}		
{01470} SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	{01470}		

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{01470}	Continued From page 14 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	{01470}		

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{01470}	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three unlicensed personnel (ULP-D, ULP-G, ULP-I) received orientation to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. During the initial survey, on October 27, 2025, at 11:13 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's record lacked evidence of orientation in the following required topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the	{01470}		

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{01470}	Continued From page 16 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. ULP-G ULP-G was hired on January 29, 2023, and provided direct care services to the facility's residents. On December 30, 2025, at 9:20 a.m., the surveyor observed ULP-G administering medications to the residents. ULP-G's record lacked evidence of orientation in the following required topics: (1) an overview of this chapter; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.	{01470}		

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{01470}	Continued From page 17 ULP-I ULP-I was hired on December 23, 2025, and provided direct care services to the facility's residents. On December 29, 2025, at 4:00 p.m., the surveyor observed ULP-I administering medications to the residents. ULP-I's record lacked evidence of orientation in the following required topics: (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 31, 2025, at 11:25 a.m., ULP-D stated some of the training had been assigned in the electronic training system but staff had not yet completed it. The licensee's undated, 5.01 Orientation of Staff and Supervisors & Content policy indicated the orientation must contain the following topics: - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints No further information was provided.	{01470}		
{01500} SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	{01500}		

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{01500}	Continued From page 18 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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:	{01500}		

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{01500}	Continued From page 19 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D, ULP-G) completed all required annual training topics for each 12 months of employment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. During the initial survey on October 27, 2025, at	{01500}		

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{01500}	Continued From page 20 11:13 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's record lacked evidence ULP-D had completed eight hours of annual training in the last 12 months of employment, and failed to complete annual training in the following required topics: - Assisted Living Bill of Rights; - Infection control techniques; - Review of provider's policies and procedures ; and - Principles of person-centered planning/service delivery. ULP-G ULP-G was hired on January 29, 2023, and provided direct care services to the facility's residents. On December 30, 2025, at 9:20 a.m., the surveyor observed ULP-G administering medications to the residents. ULP-G's record lacked evidence ULP-D had completed eight hours of annual training in the last 12 months of employment, and failed to complete annual training in the following required topics: - infection control techniques; - Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery	{01500}		

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{01500}	Continued From page 21 During the original survey on October 29, 2025, at 9:05 a.m., licensed assisted living director (LALD)-A stated they were unaware ULP-D was missing annual training and staff should have had all the required training. On December 31, 2025, at 11:25 a.m., ULP-D stated some of the training had been assigned in the electronic training system but staff had not yet completed it. The licensee's 5.06 Annual Required Staff Training dated January 1, 2024, indicated the following training elements MUST be included every 12 months to all staff who performs direct care services: - Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases - Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided.	{01500}		

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{01650}	Continued From page 22	{01650}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans contained all of the required content for all four residents (R2, R3, R4, R5) as required. This practice resulted in a level two violation (a	{01650}		

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{01650}	Continued From page 23 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: R2 R2 was admitted on September 14, 2024, and received assisted living services. On December 29, 2025, at 4:05 p.m., ULP-I was observed administering medications to R2. R2's Service Plan - Modification dated December 18, 2025, indicated R2's services included assistance bathing, grooming, medication administration, behavior management, and blood glucose monitoring. R2's service plan did not include the following required content: (1) the fees for services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	{01650}		

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{01650}	Continued From page 24 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3 was admitted on May 31, 2025, and received assisted living services. On December 29, 2025, at 4:10 p.m., ULP-I was observed administering medications to R3. R3's Service Plan - Modification dated December 18, 2025, indicated R3's services included assistance bathing, grooming, medication administration, and behavior management. R3's service plan did not include the following required content: (1) the fees for services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	{01650}		

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{01650}	Continued From page 25 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R4 R4 was admitted on February 16, 2024, and received assisted living services. On December 29, 2025, at 4:00 p.m., ULP-I was observed administering medications to R4. R4's Service Plan - Modification dated December 18, 2025, indicated R4's services included assistance bathing, grooming, medication administration, and behavior management. R4's service plan did not include the following required content: (1) the fees for services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38348	A. BUILDING: _____ B. WING _____	R 12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

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{01650}	Continued From page 26 R5 R5 was admitted on January 15, 2025, and received assisted living services. On December 30, 2025, at 9:20 a.m., the surveyor observed ULP-J administering medications to R5. R5's Service Plan - Modification dated December 18, 2025, indicated R5's services included assistance bathing, grooming, medication administration, and behavior management. R5's service plan did not include the following required content: (1) the fees for services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On December 30, 2025, at 2:45 p.m., clinical nurse supervisor (CNS)-C stated she printed out	{01650}		

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{01650}	Continued From page 27 and had them sign the incorrect service plan. CNS-C stated she came in on December 29, 2025, (the evening after the surveyor had entered), printed the correct forms and had the residents sign them. The licensee's undated, 6.08 Service Plan policy indicated service plans would have all the required content. No further information was provided.	{01650}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for all four residents (R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01760}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01760}	Continued From page 28 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: R2 R2 was admitted on September 14, 2024, and received assisted living services. On December 29, 2025, at 4:05 p.m., the surveyor observed ULP-I administering medications to R2. R2's Service Plan - Modification dated December 18, 2025, indicated R2's services included medication administration. R2's December 2025, MAR included: - furosemide 20 mg two tabs by mouth daily had an end date of December 18, 2025, furosemide 20 mg two tabs by mouth daily for two days was administered on December 26 and 27, 2025. - melatonin 20 mg take four tabs at bedtime - norethindrone-eth estradiol (was not included in the pill pack and was not present in R2's medication drawer.) R2's medication pre-set up dose pack provided by the pharmacy, did not include: - furosemide - melatonin - norethindrone-eth estradiol R2's unsigned, physician orders dated November 11, 2025, included: - norethindrone-eth estradiol 0.5-2.5 mg-mcg	{01760}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

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{01760}	Continued From page 29 (micrograms) tablet take one tablet by mouth every day; - melatonin take by mouth at bedtime. R2's physician orders dated December 22, 2025, included: - furosemide 1 tablet (40 mg) by mouth daily take 40 mg for 3 days, 12/22/25, 12/23/25, and 12/24/25, then return to previous dosing of 20 mg daily. Medication reconciliation by the surveyor identified the following: - R2's furosemide order indicated R2 was supposed to take 20 mg per day the furosemide was not on the MAR and was not included in the pre-set up dose pack from the pharmacy. - R2's unsigned orders and medication administration record included melatonin, it was not included in the pre-set up dose pack from the pharmacy. - R2 had a new order for for norethindrone-eth estradiol 0.5-2.5 mg-mcg, but it was not on the MAR or in the pre-set up dose pack. R3 R3 was admitted on May 31, 2025, and received assisted living services. R3's Service Plan - Modification dated December 18, 2025, indicated R3's services included medication administration. On December 29, 2025, at 4:10 p.m., the surveyor observed ULP-I administering medications to R3. R3's December 2025, MAR included: - buspirone was increased from 15 mg to 30 mg on December 26, 2025; and	{01760}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01760}	Continued From page 30 - gabapentin 300 mg 1 capsule three times a day. R3's medication pre-set up dose pack provided by the pharmacy included: - buspirone 30 mg 1 tablet twice a day; and - gabapentin 300 mg one capsule three times a day. R3's physician order dated December 18, 2025, indicated: - gabapentin 300 mg take two tablets 3 times a day. R3's physician order from the pharmacy dated December 3, 2025, indicated; - buspirone 30 mg by mouth every day. Medication reconciliation by the surveyor identified the following: - Although R3's gabepentin order indicated he was to take 2 capsules three times per day, the MAR indicated one capsules three times a day, and the preset-pill packs were set up for 1 capsule three times per day; and - Although R3's buspirone was increased from 15 mg to 30 mg on December 3, 2025, it was not changed on his December MAR until December 26, 2025. R4 R4 was admitted on February 16, 2024, and received assisted living services. R4's Service Plan - Modification dated December 18, 2025, indicated R4's services included medication administration. On December 29, 2025, at 4:00 p.m., the surveyor observed ULP-I administering medications to R4.	{01760}		

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{01760}	Continued From page 31 R4's December 2025, MAR included the following: - alprazolam 1 mg take one tablet four times per day, this was changed after surveyor entering to alprazolam 1 mg take 1-2 tabs by mouth twice a day; - quetiapine 25 mg one tablet every day at bedtime was changed to two tablets every night at bedtime on December 5, 2025; and - mirabegron, ferous sulfate, and folic acid were not included on the MAR. R4's medication pre-set up dose pack provided by the pharmacy included: - quetiapine 25 mg one tablet every day in the p.m.; - alprazolam was on a separate card and indicated 1 mg one po (by mouth) four times a day; - ferrous sulfate and folic acid were not provided by the pharmacy and were not in R4's medication drawer. R4's physician orders dated October 20, 2025, included: - alprazolam 1 mg take 1-2 tabs by mouth twice a day, total 4 mg; - quetiapine 25 mg one tablet at bedtime and may take an additional dose as needed - folic acid 1 mg one tab by mouth once a day - ferrous sulfate 325 mg take one tablet by mouth every other day - mirabegren 25 mg take one tablet by mouth daily Medication reconciliation by the surveyor identified the following: - alprazolam 1 mg was ordered 1-2 tablets by mouth twice daily but was being administered one	{01760}		

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{01760}	Continued From page 32 tablet four times a day; - quetiapine was ordered and being provided by the pharmacy as one tablet every evening/bedtime; however, the MAR indicated two tablets every day at bedtime and was being signed off as two tablets being administered; - Myrbetriq, ferrous sulfate, and folic acid were ordered by the physician but they were not included on the MAR or in the pharmacy dose packs or separately in the medication drawer. R5 R5 was admitted on January 15, 2025, and received assisted living services. R5's Service Plan - Modification dated December 18, 2025, indicated R5's services included medication administration. On December 30, 2025, at 9:20 a.m., the surveyor observed ULP-G administering medications to R5. ULP-G removed Victoza from the cart without checking the MAR prior to administration. Per the pharmacy label, the dose is 1.8 mg. The Victoza pen had an open date of December 20, 2025, and was almost empty. The surveyor requested ULP-G show the order on the MAR, and they were unable to locate it. On December 30, 2025, at 9:31 a.m., ULP-D stated Victoza was not on the MAR because it had been held due to a nationwide storage. The licensee was unable to obtain R5's medication for awhile and therefore it had been on hold. ULP-D noted the pen was almost empty so it had been administered by staff for awhile. R5's December 2025, MAR included the following:	{01760}		

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{01760}	Continued From page 33 - sertraline 100 mg, take 1 tablet by mouth daily; - vitamin D take one tablet by mouth daily; and - Victoza, rosuvastatin, senna laxative, and tamsulosin were not on R5's MAR. R5's medication pre-set up dose pack provided by the pharmacy included: - sertraline 100 mg tab, take 1.5 tablets daily; - vitamin D take one tablet by mouth daily; - rosuvastatin, senna laxative, and tamsulosin were not on R5's MAR. R5's physician orders dated August 19, 2025, included: - Victoza 1.8 mg subcutaneous injection daily; - vitamin D is not included in the orders; - rosuvastatin 10 mg take one by mouth every day; - senna-lax 8.6 mg take one tablet by mouth twice a day; and - tamsulosin 0.4 mg take one capsule by mouth at bedtime. R5's physician orders from pharmacy dated October 27, 2025, included: - sertraline 100 mg, take 1.5 tablet by mouth daily Medication reconciliation by the surveyor identified the following: - sertraline was ordered as 100 mg 1.5 tab daily and the pharmacy was providing 1.5 tablets daily; however, the MAR indicated one tablet daily and that is what staff had signed off on the month of December; - Vitamin D was on the MAR and was being administered by the staff; however, it was not included on the physician orders; Victoza 1.8 mg was observed being administered and it was reported it had been administered. However, it was not included on the MAR; thus, it	{01760}		

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{01760}	Continued From page 34 had not been documented as administered; - R5 had orders for rosuvastatin, senna-lax and tamsulosin; however, they were not on the MAR and were not being provided by the pharmacy. On December 31, 2025, at 4:03 p.m., clinical nurse supervisor (CNS)-C reviewed the above noted discrepancies and stated she thought she had worked out the discrepancies with the pharmacy and would have to review them again. CNS-C stated all medications should be administered as ordered. No further information provided.	{01760}		

Electronically Delivered
December 3, 2025

Licensee
Noble Residential Living
179 Pottok Lane
Shakopee, MN 55379

RE: Project Number(s) SL38348016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 29, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

0420 - 144g.40 Subdivision 1 - Responsibility For Housing And Services
0470 - 144g.41 Subdivision 1 - Minimum Requirements
0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
0550 - 144g.41 Subd. 7 - Resident Grievances; Reporting Maltreatment
0640 - 144g.42 Subd. 7 - Posting Information For Reporting Suspected C
0650 - 144g.42 Subd. 8 (a) - Staff Records

0660 - 144g.42 Subd. 9 - Tuberculosis Prevention And Control
0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness
0730 - 144g.43 Subd. 3 - Contents Of Resident Record
0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment
0830 - 144g.45 Subd. 3 - Local Laws Apply
0950 - 144g.50 Subd. 3 - Designation Of Representative
1060 - 144g.52 Subd. 9 - Emergency Relocation
1320 - 144g.60 Subd. 4 (a) - Unlicensed Personnel
1330 - 144g.60 Subd. 4 (b) - Unlicensed Personnel
1440 - 144g.62 Subd. 4 - Supervision Of Staff Providing Delegated Nurs
1470 - 144g.63 Subd. 2 - Content Of Required Orientation
1500 - 144g.63 Subd. 5 - Required Annual Training
1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring
1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To
1650 - 144g.70 Subd. 4 (f) - Service Plan, Implementation And Revisions To
1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication
1880 - 144g.71 Subd. 19 - Storage Of Medications
1890 - 144g.71 Subd. 20 - Prescription Drugs
1940 - 144g.72 Subd. 3 - Individualized Treatment Or Therapy Managemen
2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

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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: SL38348016-0 On October 27, 2025, through October 29, 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 four residents; four receiving services under the Assisted Living Facility license. An immediate correction order was identified on October 29, 2025, issued for SL38348016-0, tag identification 0775.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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	38348	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

(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
0 420	Continued From page 1 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 provide sufficient management, control, and operation of the housing and services provided by the facility. This had the 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care license, effective May 6, 2025. 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 an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I	0 420		

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0 420	Continued From page 2 have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, 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 of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all 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." Page six was electronically signed by the owner/authorized agent on March 9, 2025. As a result of this survey, the following orders were issued under 0470, 0510, 0550, 0640, 0650, 0660, 0680, 0730, 0775, 0810, 0830, 0950, 1060, 1320, 1330, 1440, 1470, 1500, 1620, 1640, 1650, 1760, 1880, 1890, 1940, and 2320, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 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	0 470		

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0 470	Continued From page 3 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, the licensee failed to ensure an accurate and current staffing schedule was posted in a central location accessible to staff, residents, volunteers, and the public according to MN rules 4659.0180, Subp. 4 (B). This practice resulted in a level one violation (a	0 470		

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0 470	Continued From page 4 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 all the residents). The findings include: The Assisted Living licensee was licensed for a capacity of 5 residents with a current census of 4 residents receiving services. During the entrance conference on October 27, 2025, at 11:46 a.m., licensed assisted living director (LALD)-A and owner (O)-B stated the usual staffing schedule for the facility was as follows: - the RN was on call 24 hours per day and was onsite once a week for 2-4 hours. - there was one ULP working every shift. Upon entrance to the facility on October 27, 2025, at 11:30 a.m. the surveyor observed a white board near the entrance that had Sunday written on it with the following: - morning with unlicensed personnel (ULP)-D's name - afternoon with ULP-D's name - overnight was blank The licensee's undated "Weekly Schedule" indicated the following: - 7:00 a.m.- 3:00 p.m. ULP-G - 3:00 p.m.- 11:00 p.m. ULP-H - 11:00 p.m.- 7:00 a.m. ULP-E On October 27, 2025, at 3:11 p.m. ULP-D stated the posting was incorrect and should have been	0 470		

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0 470	Continued From page 5 updated today. The licensee's 4.06 Staffing & Scheduling policy dated January 1, 2024, identified "The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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 infection control program that complies with accepted health care, medical and nursing standards for infection control with proper	0 510		

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0 510	Continued From page 6 hand hygiene for two of two employees (unlicensed personnel (ULP)-D, ULP-F). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 27, 2025, during continuous observation beginning at 11:13 a.m., the surveyor observed the following: - At 11:13 a.m., ULP-D stated she had just washed her hands and was going to pass the medications. ULP-D put on gloves, punched R2's medications into a medication cup, went to R2's room, picked up R2's beverage on the table in R2's room and administered the medications. ULP-D did not remove gloves, wash hands, or use hand sanitizer; - At 11:20 a.m., ULP-D punched R3's medications into a medication cup, went to R3's room and administered the medications. ULP-D did not remove gloves, wash hands, or use hand sanitizer; - At 11:22 a.m., ULP-D punched R4's medications into a medication cup, removed a prescription bottle of Flagyl (antibiotic) into her gloved hand and placed it into the medication cup, punched alprazolam (anti-anxiety) into her gloved hand and placed it into the medication	0 510		

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0 510	Continued From page 7 cup, punched buprenorphine/naloxone (treats opioid dependence) into her gloved hand and placed into the medication cup. ULP-D then went to R4's room and knocked on the door. R4 did not answer and ULP-D stated she must still be asleep and she would return with the medications later. ULP-D placed the medication cup in the file cabinet in R4's drawer. ULP-D did not remove gloves, wash hands, or use hand sanitizer; - At 11:26 a.m., ULP-D went to R5 and asked what R5's blood sugar was. ULP-D returned to the medication room, and removed R5's medications from the file cabinet and placed them on a smaller cabinet; - At 11:27 a.m., ULP-D stated R4 was awake because she put on her call light. ULP-D removed the medication cup from R4's drawer and returned to R4's room. R4 requested ULP-D take an empty bottle for water out of the garbage and fill it up. ULP-D took the bottle out of the garbage, filled it with water from the sink, wiped the outside of the bottle with a paper towel, returned to R4's room, handed her the water and administered her medications. ULP-D gave R4 a fresh can of pop, picked up the empty pop cans and exited the room. ULP-D emptied what was left in the pop cans into the sink and threw the cans away. ULP-D did not remove gloves, wash hands, or use hand sanitizer; - At 11:32 a.m. ,ULP-D returned to the office and punched R5's medications into a medication cup, removed two bottles of eye drops, and approached R5 in a common area. R5 requested the eye drops be administered first. ULP-D held open the left eye and placed one of the eye drops in that eye, held open the right eye and placed a drop from the other bottle in that eye. ULP-D observed R5 take the furosemide. ULP-D returned to the office, returned the eye drops to	0 510		

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0 510	Continued From page 8 the drawer, removed her gloves and stated the medication pass was complete. ULP-D wore the same gloves and did not wash hands or use hand sanitizer throughout the entire observation. On October 28, 2025, during continuous observation beginning at 7:39 a.m., the surveyor observed the following: - At 7:39 a.m., ULP-F washed hands and put on gloves. ULP-F removed R2's medications from the file cabinet, punched Viibryd into her gloved hand and placed it into the medication cup, punched methocarbamol (muscle relaxer) into her gloved hand and placed it into the medication cup, filled polyethylene glycol (constipation) cap, removed a bottle of Gatorade and poured some into a glass, mixed the polyethylene glycol with the Gatorade. ULP-F went to R2's room, administered the oral medications and placed the polyethylene glycol mixture on the night stand. ULP-F removed an inhaler from R2's bedside stand and handed it to R2 who self administered, and ULP-F returned the inhaler to the drawer. R2 drank her polyethylene glycol mixture. ULP-F did not remove gloves, wash hands, or use hand sanitizer; - At 8:07 a.m., ULP-F removed R3's medications from the file cabinet and punched them into a medication cup. ULP-F went to R3's room and administered the oral medications. ULP-F did not remove gloves, wash hands, or use hand sanitizer; - At 8:12 a.m., ULP-F removed R5's medication from the file cabinet, punched into a medication cup, and removed Victoza (injectable diabetes medication), and two eye drops from the drawer. ULP-F administered the oral medications, ULP-F handed R5 the Victoza and the pen needle. R5	0 510		

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0 510	Continued From page 9 placed the pen needle on the pen and injected the medication. R5 did not clean the port prior to placing the needle and did not clean his skin prior to injecting. ULP-F did not cue R5 to clean the port or his skin. ULP-F held open left eye and placed a drop in and then held open the right eye and placed a drop from the other bottle in. ULP-F stated her med pass was complete and she removed her gloves. ULP-F wore the same gloves and did not wash hands or use hand sanitizer throughout the entire observation. On October 29, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-C stated staff should be changing gloves and using hand sanitizer or washing hands between residents. The staff should not have taken the bottle out of the trash and reused it. CNS-C further stated when administering insulin or Victoza, staff should always clean the port before putting on the needle and should clean the skin prior to injection. R5 should not have self administered the Victoza; staff should have administered the Victoza using proper infection control measures. The licensee's undated, 1.04 Infection Control policy included the following: Hand Washing Proper hand washing technique is the number one step you can take to prevent the spread of infection. Hand Washing should be completed -Before, during, and after preparing food -Before eating food -Before and after caring for someone who is sick -Before and after treating a cut or wound -After using the toilet -After changing diapers or cleaning up after someone who has used the toilet	0 510		

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0 510	Continued From page 10 -After blowing your nose, coughing, or sneezing -After touching an animal or animal waste -After handling pet food or pet treats -After touching garbage When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. Alcohol-Based Hand Sanitizers (ABHS) ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. However, if hands are not visibly soiled, or soap and water are not readily available. An alcohol based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands. There is no limit to the number of times you can use ABHS before you must use soap and water. A good rule of thumb though is to wash with soap and water when hands are visibly soiled, after completing cares for someone with C-Diff or norovirus, and when the hands have a "filmy" feel to them. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of	0 550		

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0 550	Continued From page 11 Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed have all the required contact in the posted grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 27, 2025, at 12:45 p.m., the surveyor observed a complaint posting on a board near the entry. The licensee's undated, [Facility] Grievance/Complaint Concerns posted included the name and phone number for licensed assisted living director (LALD)-A. The posting did not include the following required information:	0 550		

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0 550	Continued From page 12 - email information for LALD-A; - contact information for the Office of Ombudsman for Long-Term Care; - contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; - information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center; - a statement that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health and their contact information. A separate document posted included the contact information for Office of Ombudsman for Mental Health and Developmental Disabilities and other agencies; however, the document did not include the additional required contact information. On October 27, 2025, at 1:11 p.m., unlicensed personnel (ULP)-D stated she was unaware the grievance posting did not have the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in	0 640		

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0 640	Continued From page 13 common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and information for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 October 27, 2025, at 12:45 p.m., the surveyor observed a posting with information and contact information for MAARC. The posting did not include calling 911 in an emergency. The surveyor observed a facility desk and portable phone in the facility's office. The phones did not have postings on or near the phone to call 911 in an emergency.	0 640		

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0 640	Continued From page 14 On October 27, 2025, at 1:11 p.m., unlicensed personnel (ULP)-D stated she was unaware 911 had to be posted in common areas of the facility and near facility phones. The licensee's undated, 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy indicated the facility will support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: a. Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

(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
0 650	Continued From page 15 (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 observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-D, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. On October 27, 2025, at 11:13 a.m., the surveyor observed ULP-D administering medications to the residents.	0 650		

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0 650	Continued From page 16 ULP-D's employee lacked evidence of completion of any competency evaluations, by a registered nurse, including medication administration, blood glucose monitoring, and other treatments. In addition, ULP-D's record did not include an annual performance evaluation that identified areas of improvement needed and training needs. ULP-F ULP-F was hired on August 11, 2025, and provided direct care services to the facility's residents. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to the residents. ULP-F's employee record lacked evidence of completion of any competency evaluations, by a registered nurse, including medication administration, blood glucose monitoring, and other treatments. ULP-F's employee record lacked evidence of tuberculosis testing. ULP-F's record included a physician's note dated August 12, 2025, indicating ULP-F had a chest x-ray on August 12, 2025, and there was no evidence of active TB. On October 28, 2025, 10:42 a.m., clinical nurse supervisor CNS-C stated she trains the staff on medication administration and then observes them completing a medication pass three times after that training., Then, CNS-A completes two follow up observations on medication passes and treatments.	0 650		

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0 650	Continued From page 17 On October 28, 2025, at 1:10 p.m., the surveyor observed licensed assisted living director (LALD)-A and ULP-D filling out competency forms. ULP-D stated she had been trained and competency tested by the registered nurse (RN), but the RN at the time had not completed any documentation of the competency testing; therefore, they were completing the forms to provide to the surveyor. LALD-A and ULP-D further stated they were unaware competency testing needed to be documented. On October 28, 2025, 1:30 p.m., ULP-F stated the first week she watched the videos, then trained with CNS-C. Then, CNS-C watched her administer medications and complete blood glucose testing prior to her completing those tasks on her own. ULP-F further stated this training and observing also included assisting the residents with ADLs. On October 29, 2025, at 9:05 a.m., ULP-D stated the nurse competency tested for ADLs, medication administration and blood glucose monitoring, but it wasn't documented. On October 29, 2025, at 1:38 a.m., ULP-D stated there was no performance evaluation completed and they were unaware of the requirement. On October 28, 2025, at 10:54 a.m., ULP-D stated ULP-F's TB blood test had been completed and it was inconclusive, so the chest x-ray was completed. ULP-D further stated she would get the TB blood test results from the provider. The licensee's undated, 4.05 Employee Records	0 650		

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0 650	Continued From page 18 policy indicated employee records for each person will include: - Records of all training and in-service education required and/or provided including record of competency testing as required - Documentation of annual performance reviews that identify areas of improvement needed and training needs - For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file) - Verification of completed orientation and annual training and competency testing as required. 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.	0 660		

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0 660	Continued From page 19 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB screening upon hire for two of two employees (unlicensed personnel (ULP)-D, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. On October 27, 2025, at 11:13 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's employee record included a tuberculosis blood test completed on January 13, 2023. ULP-D's record lacked evidence of a Baseline TB (tuberculosis) Screening Tool for Health Care	0 660		

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0 660	Continued From page 20 Workers. ULP-F ULP-F was hired on August 11, 2025, and provided direct care services to the facility's residents. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to the residents. ULP-F's employee record lacked evidence of a Baseline TB (tuberculosis) Screening Tool for Health Care Workers. On October 29, 2025, 9:20 a.m., LALD-A stated he was unaware of the TB screening tool and therefore none of the staff would have it. The licensee's 8.16 Tuberculosis Screening policy dated January 1, 2024, indicated new staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 21 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of 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:	0 680		

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0 680	Continued From page 22 The licensee provided a three ring binder labeled Emergency Preparedness Manual, last reviewed May 1, 2025. The EPP was received from a consulting group. The policies indicated the facility would have policies, but they were not individualized to the facility. The EPP lacked evidence of the following required content: - missing resident plan last reviewed January 1, 2023. The plan was not reviewed quarterly as required; - identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - identify a qualified person who is authorized in writing to act in the absence of the administrator; - policies to address food, medical supplies, pharmaceutical supplies, sewage and waste; - policy to address use of volunteers including the process/role for integration; - contact information for State Licensing and Certification Agency; - a communication plan which includes: primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; - communication plan that included: -Method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care -Means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -Means of providing information about general condition/ location of residents under the	0 680		

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0 680	Continued From page 23 facility's care as permitted under 45 CFR 164.510(b)(4) - a means to provide information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and -emergency prep testing requirements for two full scale drills or one full scale drill and one tabletop exercise completed annually. On October 17, 2025, at 2:45 p.m., licensed assisted living director (LALD)-A stated they used a consulting agency's EPP and he was unaware the emergency plan was missing the required information as noted above. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;	0 730		

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0 730	Continued From page 24 (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	0 730		

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0 730	Continued From page 25 Based on interview and record review, the licensee failed to complete a discharge summary with the required content for one of one discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's record included a Resident Discharge Summary dated August 31, 2023, indicating R1 was transferred to a hospital for increasing pain and care needs related to their cancer diagnosis. R1's record did not include a written discharge summary, provided to the resident, representative and case manager, which included the following required content: - A summary of the resident's stay that includes diagnoses, courses of illness, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - A final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; - A reconciliation of all pre-discharge medications with the resident's post discharge prescribed and over the counter medications; and	0 730		

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0 730	Continued From page 26 - A post discharge plan that is developed with the resident and, with the resident's consent, the residents representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and non-medical services the resident will need. On October 27, 2025, at 12:41 p.m., licensed assisted living director (LALD)-A stated R1 was discharged to the hospital because of increased pain and care needs with his cancer diagnosis. LALD-A stated R1 was subsequently transferred to a nursing home and passed away there. LALD-A further stated they were unaware of the required content in a discharge summary. On October 27, 2025, at 1:05 p.m., clinical nurse supervisor (CNS)-C stated she was unaware of the required content in a discharge summary. The licensee's undated, 2.38 Resident Record - Information and Content policy indicated the resident record would include a discharge summary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=H	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide resident sleeping rooms with egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. Egress windows in the facility failed to meet the minimum window opening requirement to comply with state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 29, 2025, from approximately 12:55 p.m. to 2:05 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor asked LALD-A to open the windows in the resident sleeping rooms for measurement and the surveyor measured the openable area of the windows. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: -Resident sleeping room 3: Two windows each measuring 33 inches clear width, 17 inches clear height, and 561 square inches total openable	0 775		

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0 775	Continued From page 28 area. RESULTS: -The windows in resident sleeping room 3 did not meet the minimum requirements for opening height. -The windows in resident sleeping room 3 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Each resident room must have at least one compliant means of egress. Surveyor explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD-A stated that they had been unaware of the specific size requirements but confirmed understanding of the requirements stated by the surveyor during the survey and requirement to obtain any applicable permits for alterations. On October 29, 2025, the surveyor explained to LALD-A that an immediate correction order was issued for the above findings. LALD-A stated they understood the requirements for egress windows and would immediately start the process of getting the windows replaced. TIME PERIOD FOR CORRECTION: Immediate.	0 775		

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0 810	Continued From page 29	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38348	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

(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
0 810	Continued From page 30 by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 29, 2025, at approximately 2:00 p.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. Provided home care consultant documents were not specific to the building and contained general information on fire safety, but did not contain specific employee actions for evacuation or fire for the facility. The FSEP failed to include appropriate resident actions to take during a fire or similar emergency. Provided home care consultant documents were not specific to the building and contained general	0 810		

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0 810	Continued From page 31 information on fire safety, but did not contain specific employee actions for evacuation or fire for the facility. During an interview on October 29, 2025, at approximately 2:20 p.m., the surveyor explained the requirements for site specific policies and FSEP documentation. LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R2). This had the potential to affect all staff, residents, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 830	Continued From page 32 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 October 28, 2025, at 1:18 p.m., the surveyor was walking towards the entrance to the facility and observed the garage door was open with R2 sitting just inside the garage, smoking a cigarette. R2 was sitting within the garage which was enclosed on three sides. On October 29, 2025, at 1:52 p.m., licensed assisted living director (LALD)-A stated residents are not to smoke in the garage, they are to go outside by a tree. LALD-A stated R2 must have known they were busy yesterday and believed they wouldn't notice. The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital,	0 830		

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0 830	Continued From page 33 health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the	0 950		

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0 950	Continued From page 34 designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required verbatim language giving residents the right to identify a designated representative on it's own separate page for two of two residents (R2 and R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted to the assisted living licensee on September 13, 2024. R2's Resident Contract for Assisted Living signed September 12, 2024, Resident Agreement signed June 1, 2024, page one included "Designated Representative" with lines to fill in and under that statement and lines was the statement "If Resident declines to name a Designated Representative, Resident please initial here" with a line the resident could initial both were left	0 950		

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0 950	Continued From page 35 blank. R2's contract did not identify a designated representative and the line to initial if the resident declines a designated representative was left blank. Page two of the contract included "You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney C-health care agent"), if applicable. R2's records lacked evidence they had been provided the following verbatim notice on a document separate from the contract as required: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R5 R5 was admitted to the assisted living licensee on February 1, 2023. R5's Resident Agreement signed February 1, 2023, page one included "Designated Representative" with lines to fill in and under that	0 950		

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0 950	Continued From page 36 statement and lines was the statement "If Resident declines to name a Designated Representative, Resident please initial here" with a line the resident could initial both were left blank. R5's contract did not identify a designated representative and the line to initial if the resident declines a designated representative was left blank. Page two of the contract included "You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney C-health care agent"), if applicable. R5's records lacked evidence they had been provided the following verbatim notice on a document separate from the contract as required: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On October 27, 2025, at 2:25 p.m., unlicensed personnel (ULP)-D stated none of the residents had a designated representative and they were	0 950		

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0 950	Continued From page 37 unaware the resident needed to initial if declining designate a representative, In addition, ULP-D was unaware the verbatim statement must be provided on a document separate from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060		

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01060	Continued From page 38 may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with all the required content to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record included a Resident Discharge Summary dated August 31, 2023, indicating R1	01060		

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01060	Continued From page 39 was transferred to a hospital for increasing pain and care needs related to their cancer diagnosis. R1's record did not include documentation of notification of emergency transfer including the following: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. currently known; and	01060		

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01060	Continued From page 40 On October 27, 2025, at 12:41 p.m., licensed assisted living director (LALD)-A stated R1 was discharged to the hospital because of increased pain and care needs with their cancer diagnosis. LALD-A stated R1 was subsequently transferred to a nursing home and passed away there. LALD-A further stated they were unaware of the requirement for emergency transfer documentation and notification. On October 27, 2025, at 1:05 p.m., clinical nurse supervisor (CNS)-C stated she was unaware of the requirement for emergency transfer. The licensee's 1.23 Emergency Relocation policy dated January 1, 2024, indicated the following: 1. In the event of an emergency relocation, Noble Residential Living will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon	01060		

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01060	Continued From page 41 as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by:	01320		

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01320	Continued From page 42 Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two employees (unlicensed personnel (ULP)-D, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. On October 27, 2025, at 11:13 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's record lacked evidence of training and/or competency testing in the following required topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic	01320		

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01320	Continued From page 43 devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (7) standby assistance techniques and how to perform them; (11) 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; (13) understanding appropriate boundaries between staff and residents and the resident's family; and (15) awareness of commonly used health technology equipment and assistive devices. ULP-D's employee record lacked evidence of completion of any competency evaluations, by a registered nurse, including medication administration, blood glucose monitoring, and other treatments. On October 29, 2025, at 9:05 a.m., ULP-D stated the nurse competency tested for ADLs, medication administration and blood glucose monitoring, but it wasn't documented. ULP-F ULP-F was hired on August 11, 2025, and provided direct care services to the facility's residents. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to the residents. ULP-F's employee lacked evidence of completion of any competency evaluations, by a registered nurse, including medication administration, blood glucose monitoring, and other treatments.	01320		

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	38348	A. BUILDING: _____ B. WING _____	10/29/2025

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NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

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01320	Continued From page 44 ULP-F's record lacked evidence of training and/or competency testing in the following required topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; and (15) awareness of commonly used health technology equipment and assistive devices. On October 28, 2025, 1:30 p.m., ULP-F stated the first week she watched the videos, then trained with CNS-C, and then CNS-C watched her administer medications and complete blood glucose testing prior to her completing those tasks on her own. ULP-F further stated this training and observing also included assisting the residents with ADLs. On October 28, 2025, 10:42 a.m., clinical nurse supervisor CNS-C stated she trains the staff on medication administration and then observes them completing a medication pass three times. Then CNS-C completes two follow up	01320		

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01320	Continued From page 45 observations on medication passes and treatments. CNS-C was unaware of the missing required trainings for the ULP. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2024, included 5. Training and competency evaluations for all ULPs will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) 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 l) awareness of confidentiality and privacy	01320		

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01320	Continued From page 46 m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
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: Based on observation, interview, and record review, the licensee failed to ensure training and	01330		

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01330	Continued From page 47 competency evaluations were completed as required prior to providing direct care for two of two employees (unlicensed personnel (ULP)-D, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. On October 27, 2025, at 11:13 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's record lacked evidence of training and/or competency testing in the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident;	01330		

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01330	Continued From page 48 (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. On October 29, 2025, at 9:05 a.m., ULP-D stated the nurse competency tested for ADL's, medication administration and blood glucose monitoring, but it wasn't documented. ULP-F ULP-F was hired on August 11, 2025, and provided direct care services to residents residing in the facility. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to the residents. ULP-F's employee lacked evidence of completion of any competency evaluations, by a registered nurse, including medication administration, blood glucose monitoring, and other treatments. ULP-F's record lacked evidence of training and/or competency testing in the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01330		

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01330	Continued From page 49 (7) administering medications or treatments as required. On October 28, 2025, at 1:30 p.m., ULP-F stated the first week she watched the videos, then trained with CNS-C, and then CNS-C watched her administer medications and complete blood glucose testing prior to her completing those tasks on her own. ULP-F further stated this training and observation also included assisting the residents with ADL's. On October 28, 2025, at 10:42 a.m., clinical nurse supervisor CNS-C stated she trains the staff on medication administration and then observes them completing a medication pass three times. Then, CNS-C completes two follow up observations on medication passes and treatments. CNS-C was unaware of the missing required trainings for the ULPs The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2024, included training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning	01330		

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01330	Continued From page 50 g. Administering medications or treatments as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01440		

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01440	Continued From page 51 review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of one unlicensed personnel (ULP-F). 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: ULP-F was hired on August 11, 2025, and provided direct care services to the facility's residents. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to the residents. ULP-F's employee record lacked evidence a RN conducted direct supervision of delegated nursing tasks within 30 days of first providing those services. On October 29, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-C stated ULP-F did not have a supervision conducted within 30 days. The licensee's 6.17 Supervision of Staff - Delegated Services dated January 1, 2023, indicated	01440		

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01440	Continued From page 52 direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct 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	01470		

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01470	Continued From page 53 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-F) received orientation to include all required content.	01470		

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01470	Continued From page 54 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: ULP-F was hired on August 11, 2025, and provided direct care services to the facility's residents. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to the residents. ULP-F's employee file lacked evidence the following required orientation had been completed: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. On October 29, 2025, at 9:05 a.m., licensed assisted living director (LALD)-A stated he was unaware ULP-F had not completed all of the required orientation topics. The licensee's undated, 5.01 Orientation of Staff	01470		

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01470	Continued From page 55 and Supervisors & Content policy indicated the orientation must contain the following topics: - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	01500		

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01500	Continued From page 56 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one	01500		

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01500	Continued From page 57 employee (unlicensed personnel (ULP)-D) completed all required annual training topics for each 12 months of employment. 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: ULP-D was hired on January 7, 2023, and provided direct care services to the residents residing within the facility. On October 27, 2025, at 11:13 a.m., the surveyor observed ULP-D administering medications to the residents. ULP-D's record lacked evidence ULP-D had completed the following annual training in the last 12 months of employment: - Assisted Living Bill of Rights; - Infection control techniques; - Review of provider's policies and procedures ; and - Principles of person-centered planning/service delivery. On October 29, 2025, at 9:05 a.m., licensed assisted living director (LALD)-A stated they were unaware ULP-D was missing annual training and staff should have had all the required trainings and competencies.	01500		

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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
01500	Continued From page 58 The licensee's 5.06 Annual Required Staff Training dated January 1, 2024, indicated the following training elements MUST be included every 12 months to all staff who performs direct care services: - Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases - Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	01620		

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	38348	A. BUILDING: _____ B. WING _____	10/29/2025

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01620	Continued From page 59 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based 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	01620		

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01620	Continued From page 60 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment including all required information in the Uniform Assessment Tool for all four residents (R2, R3, R4, R5) 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 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: R2 R2 was admitted on September 14, 2024, and received assisted living services. On October 27, 2025, at 11:13 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R2. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to R2.	01620		

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01620	Continued From page 61 R2's service plan dated September 13, 2025, indicated R2's services included assistance with dressing, grooming, bathing and medication administration. R2's record included the following assessments: - Uniform Assessment Tool dated September 15, 2025 - on the bottom of the document was a section titled Ongoing Monitoring & Reassessment, with the following information completed: - 14-Day Assessment - Date of Assessment: dated September 29, 2025 - Method: face to face/in-person marked - Notes: Discussed preferences for outings and social activities within the facility/activities calendar updated. The 14-day assessment did not include all required content of the Uniform assessment tool. R3 R3 was admitted on May 31, 2025, and received assisted living services. On October 27, 2025, at 11:20 a.m., the surveyor observed ULP-D administering medications to R3. On October 28, 2025, at 8:07 a.m., the surveyor observed ULP-F administering medications to R3. R3's service plan signed June 2, 2025, indicated R3's services included assistance with dressing, grooming, bathing, medication set-up and monitoring, medication administration, "cognitive mental health need 1" and "cognitive mental	01620		

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01620	Continued From page 62 health need 2". R3's record included the following assessments: - Uniform Assessment Tool dated May 31, 2025; - on the bottom of the document was a section titled Ongoing Monitoring & Reassessment, with the following information completed; - 14-Day Assessment - Date of Assessment: dated June 14, 2025 - Method: face to face/in-person marked - Notes: "Resident found to be forgetful staff will begin administering medications" - Updates/changes to service plan: "assistance with meds (medications). Medication administration" The 14-day assessment did not include all required content of the Uniform assessment tool. In addition, a significant change was identified and service changes were made; however, a comprehensive assessment was not completed; - 90 day assessments - Date of Assessment: dated August 31, 2025 - Method: face to face/in-person marked - Notes: "Reports needing assistance with transportation, appointments" - Updates/changes to service plan: "Staff to assist with coordinating appointments, LN(licensed nurse) to reorder meds" The 90 day assessment did not include all required content of the Uniform assessment tool. In addition, a significant change was identified and service changes were made; however, a comprehensive assessment was not completed. R4 R4 was admitted on February 16, 2024, and received assisted living services. On October 27, 2025, at 11:22 a.m., the surveyor	01620		

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01620	Continued From page 63 observed ULP-D administering medications to R4. R4's service plan dated February 16, 2025, indicated R4's services included assistance with dressing, grooming, bathing, medication set-up and medication administration. R4's record included the following assessments: - Uniform Assessment Tool dated February 16, 2025; - on the bottom of the document was a section titled Ongoing Monitoring & Reassessment, with the following information completed: - 14-Day Assessment - Date of Assessment: dated March 2, 2025 - Method: face to face/in-person marked - Notes: "Reports being wobbly when transferring out of the shower" - Updates/changes to service plan: "Requires set-up and assist x 1 with showers" - The 14-day assessment did not include all required content of the Uniform assessment tool. In addition, a significant change was identified and service changes were made, however; a comprehensive assessment was not completed; 90 day assessments - Date of Assessment: dated May 16, 2025 - Method: face to face/in-person marked - Notes: "[R4] reports worsen bilateral leg swelling" - Updates/changes to service plan: "provider notified. Lasix and potassium ordered" The 90 day assessment did not include all required content of the Uniform assessment tool. No further assessments were provided. The assessments were reviewed by the surveyor on October 29, 2025, this was 151 days since the last assessment.	01620		

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01620	Continued From page 64 R5 R5 was admitted on January 15, 2025, and received assisted living services. On October 27, 2025, at 11:32 a.m., the surveyor observed ULP-D administering medications to R5. On October 28, 2025, at 8:12 a.m., the surveyor observed ULP-F administering medications to R5. R5's service plan dated February 1, 2025, indicated R5's services included dressing, grooming, bathing, and medication administration. R5's record included the following assessments: - Uniform Assessment Tool dated February 1, 2025 - on the bottom of the document was a section titled Ongoing Monitoring & Reassessment, with the following information completed: - 14-Day Assessment - Date of Assessment: dated February 15, 2025 - Method: face to face/in-person marked - Notes: "updates made to food menu, to reflect dietary preference" - Updates/changes to service plan: "no" The 14 day assessment did not include all required content of the Uniform assessment tool. - 90 day assessments - Date of Assessment: dated May 1, 2025 - Method: face to face/in-person marked - Notes: "Change the amiodarone dose, updated in the MAR" - Updates/changes to service plan: "no"	01620		

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01620	Continued From page 65 The 90 day assessment did not include all required content of the Uniform assessment tool. - Date of Assessment: dated August 1, 2025 - Method: face to face/in-person marked - Notes: "[R5] is more withdrawn socially, increased isolation behaviors, MH (mental health) provider aware" - Updates/changes to service plan: "socialization activity updates" The 90 day assessment did not include all required content of the Uniform assessment tool. In addition, this was 92 days between assessments. On October 28, 2025, at 3:05 p.m., clinical nurse supervisor (CNS)-C stated they were unaware the assessments were completed late and they were unaware that every assessment and reassessment required the use of the uniform assessment tool. The licensee's 6.03 Uniform Assessment Tool dated January 1, 2024, indicated the licensee's "uniform assessment tool will address the following: A. The resident's personal lifestyle preferences, including: (1) Sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life (2) Spiritual and cultural preferences, and (3) Advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life sustaining treatment" order B. Activities of daily living, including:	01620		

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01620	Continued From page 66 (1) Toileting pattern, bowel, and bladder control (2) Dressing, grooming, bathing, and personal hygiene (3) Mobility, including ambulation, transfers, and assistive devices, and (4) Eating, dental status, oral care, and assistive devices and dentures, if applicable C. Instrumental activities of daily living, including: (1) Ability to self-manage medications (2) Housework and laundry, and (3) Transportation D. Physical health status, including: (1) A review of relevant health history and current health conditions including medical and nursing diagnoses (2) Allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening (3) Infectious conditions (4) A review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) The reason taken (b) Any side effects, contraindications, allergic or adverse reactions, and actions to address these issues (c) dosage (d) Frequency of use (e) Route administered or taken (f) Any difficulties the resident faces in taking the medication (g) Whether the resident self-administers the medication (h) The resident's preferences in how to take medication (i) Interventions needed in management of	01620		

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01620	Continued From page 67 medications to prevent diversion of medications by the resident or others who may have access to the medications (j) Provide instructions to the resident and the resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications (5) A review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility (6) A review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months (7) Weight, and (8) Initial vital signs if indicated by health conditions or medications E. Emotional and mental health conditions, including: (1) Review of history of and any diagnoses of mood disorders including depression, anxiety, bipolar disorder, and thought or behavioral disorders (2) Current symptoms of mental health conditions and behavioral expressions of concerns, and (3) Effective medication treatment and non-medication interventions F. Cognition, including: (1) Review of any neurocognitive evaluations and diagnoses, and (2) Current memory, orientation, confusion, and decision-making status and ability G. Communication and sensory capabilities, including: (1) Hearing (2) Vision	01620		

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01620	Continued From page 68 (3) Speech (4) Assistive communication and sensory devices including hearing aids, and (5) The ability to understand and be understood H. Pain, including: (1) Location, frequency, intensity, and duration, and (2) Effectiveness of medication and non-medication alternatives I. Skin conditions J. Nutritional and hydration status and preferences K. List of treatments, including type, frequency, and level of assistance needed L. Nursing needs, including potential to receive nursing-delegated services M. Risk indicators, including: (1) Risk for falls including history of falls (2) Emergency evacuation ability (3) Complex medication regimen (4) Risk for dehydration including history of urinary tract infections and current fluid intake pattern (5) Risk for emotional or psychological distress due to personal losses (6) Unsuccessful prior placements (7) Elopement risk including history or previous elopements (8) Smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property, and (9) Alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician N. Who has decision-making authority for the resident, including: (1) The presence of any advance health care directive or other legal document that establishes a substitute decision maker, and	01620		

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01620	Continued From page 69 (2) The scope of decision-making authority of a substitute decision maker under subitem O. The need for follow-up referrals for additional medical or cognitive care by health professionals." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	01640		

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01640	Continued From page 70 by: Based on observation, interview, and record review, the licensee failed to ensure service plan modifications were completed and signed when the resident's services changed for all four residents (R2, R3, R4, R5) 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 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: R2 R2 was admitted on September 14, 2024, and received assisted living services. On October 27, 2025, at 11:13 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R2. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to R2. R2's Resident Profile printed October 28, 2025, indicated R2's current services included bathing, escort, grooming, incontinence care, behaviors of anxiety, mental health need, verbal aggression, transfer assistance, ambulation, CPAP (continuous positive airway pressure-used to treat sleep apnea), hearing aid assistance, medication administration, continuous blood	01640		

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01640	Continued From page 71	01640		

glucose monitor, and blood glucose monitoring.

R2's service plan dated September 13, 2025, indicated R2's services included assistance with dressing, hair care, bathing, stand-by assistance getting in and out of the shower, medication administration, and medication administration. It also indicated R2 was independent with toileting. The service plan did not include escorts, incontinence care, behaviors of anxiety, mental health need, verbal aggression, ambulation, CPAP, hearing aid assistance, continuous blood glucose monitor, and blood glucose monitoring,

R3
R3 was admitted on May 31, 2025, and received assisted living services.

On October 27, 2025, at 11:20 a.m., the surveyor observed ULP-D administering medications to R3.

On October 28, 2025, at 8:07 a.m., the surveyor observed ULP-F administering medications to R3.

R3's record included the following assessments:
- 14-Day Assessment
  - Date of Assessment: dated June 14, 2025
  - Method: face to face/in-person marked
  - Notes: "Resident found to be forgetful staff will begin administering medications"
  - Updates/changes to service plan: "assistance with meds (medications). Medication administration"
- 90 day assessments
  - Date of Assessment: dated August 31, 2025
  - Method: face to face/in-person marked
  - Notes: "Reports needing assistance with

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transportation, appointments"
- Updates/changes to service plan: "Staff to assist with coordinating appointments, LN(licensed nurse) to reorder meds"

R3's Resident Profile printed October 28, 2025, indicated R3's current services included dressing, grooming, bathing, behaviors of anxiety, other mental health need, agitation, socialization, medication administration, and ambulation.

R3's service plan signed June 2, 2025, indicated R3's services included assistance with dressing, grooming, bathing, transfers, Medication set-up and monitoring, added on was medication administration, "cognitive mental health need 1" and "cognitive mental health need 2". R3's service plan did not include behaviors of anxiety, other mental health need, agitation, socialization, and ambulation.

R4
R4 was admitted on February 16, 2024, and received assisted living services.

On October 27, 2025, at 11:22 a.m., the surveyor observed ULP-D administering medications to R4.

R4's record included the following assessments:
- 14-Day Assessment
- Date of Assessment: dated March 2, 2025
- Method: face to face/in-person marked
- Notes: "Reports being wobbly when transferring out of the shower"
- Updates/changes to service plan: "Requires set-up and assist x 1 with showers"

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	38348	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

(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
01640	Continued From page 73 R4's Resident Profile printed October 28, 2025, indicated R4's current services included appointment reminders, bathing, grooming, incontinence care, manage behaviors of agitation, verbal aggression, depression, socialization, transportation assist, ambulation, and medication and ministration. R4's service plan dated February 16, 2025, indicated R4's services included assistance with dressing, grooming, bathing, medication set-up and medication administration. R4's service plan did not include appointment reminders, incontinence care, manage behaviors of agitation, verbal aggression, depression, socialization, and transportation assist. R5 R5 was admitted on January 15, 2025, and received assisted living services. On October 27, 2025, at 11:32 a.m., the surveyor observed ULP-D administering medications to R5. On October 28, 2025, at 8:12 a.m., the surveyor observed ULP-F administering medications to R5. R5's record included the following assessments: 90-day assessment - Date of Assessment: dated August 1, 2025 - Method: face to face/in-person marked - Notes: "[R5] is more withdrawn socially, increased isolation behaviors, MH (mental health) provider aware" - Updates/changes to service plan: "socialization activity updates"	01640		

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01640	Continued From page 74 R5's Resident Profile printed October 27, 2025, indicated R5's services included medication administration, incontinence care, manage behaviors of agitation, anxiety and self isolation, socialization, and blood glucose monitoring. R5's service plan dated February 1, 2025, indicated R5's services included dressing, grooming, bathing, and medication administration. Dressing, grooming and bathing were not included on R5's Resident Profile; therefore, he was not receiving those services. R5's service plan did not include incontinence care, manage behaviors of agitation, anxiety and self isolation, socialization, and blood glucose monitoring. On October 28, 2025, at 3:05 p.m., clinical nurse supervisor (CNS)-C stated they were unaware the service plans did not match the residents' current services. The service plan should be updated and signed with any changes. CNS-C stated she would update the current written service plans when changes were made according to the assessment, but she did not complete a new service plan or a modification to be signed documenting agreement of the changes to the services. The licensee's undated, 6.08 Service Plan policy indicated the service plan and any revisions shall include a signature or other authentication by [licensee name] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided.	01640		

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01640	Continued From page 75 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01650		

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01650	Continued From page 76 review, the licensee failed to ensure service plans contained all of the required content for all four residents (R2, R3, R4, R5) 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 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: R2 R2 was admitted on September 14, 2024, and received assisted living services. On October 27, 2025, at 11:13 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R2. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to R2. R2's service plan dated September 13, 2025, indicated R2's services included assistance with dressing, hair care, bathing, stand by assistance getting in and out of the shower, medication administration, and medication administration. R2's service plan did not include the fee for services R3 R3 was admitted on May 31, 2025, and received assisted living services.	01650		

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01650	Continued From page 77 On October 27, 2025, at 11:20 a.m., the surveyor observed ULP-D administering medications to R3. On October 28, 2025, at 8:07 a.m., the surveyor observed ULP-F administering medications to R3. R3's service plan signed June 2, 2025, indicated R3's services included assistance with dressing, grooming, bathing, transfers, medication set-up and monitoring, added on was medication administration, "cognitive mental health need 1" and "cognitive mental health need 2". R3's service plan did not include the fee for services R4 R4 was admitted on February 16, 2024, and received assisted living services. On October 27, 2025, at 11:22 a.m., the surveyor observed ULP-D administering medication to R4. R4's service plan dated February 16, 2025, indicated R4's services included assistance with dressing, grooming, bathing, medication set-up and medication administration. R4's service plan did not include the fee for services. R5 R5 was admitted on January 15, 2025, and received assisted living services. On October 27, 2025, at 11:32 a.m., the surveyor observed ULP-D administering medications to R5.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 78 On October 28, 2025, at 8:12 a.m., the surveyor observed ULP-F administering medications to R5. R5's service plan dated February 1, 2025, indicated R5's services included dressing, grooming, bathing, and medication administration. Dressing, grooming and bathing were not included on R5's Resident Profile; therefore, R5 was not receiving those services. In addition, R5's service plan did not include the fee for services. On October 28, 2025, at 3:05 p.m., clinical nurse supervisor (CNS)-C stated the residents were all on waiver services and she should have marked that on their service plans. The licensee's undated, 6.08 Service Plan policy indicated service plans shall include fees for the services indicated in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 79 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for all four residents (R2, R3, R4, R5). 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: R2 R2 was admitted on September 14, 2024, and received assisted living services. On October 27, 2025, at 11:13 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R2. R2's service plan dated September 13, 2025, indicated R2's services included assistance with medication administration. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to	01760		

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01760	Continued From page 80 R2. ULP-F removed the pre-set up dose pack from the pharmacy and checked the names of the medications to the medication administration record (MAR). The following was observed: - furosemide 20 milligrams (mg) one by mouth every day as needed. ULP-F stated the furosemide wasn't in the dose pack so she had to use the as needed dose, and placed one tablet into the medication cup; - ULP-F removed the polyethylene glycol from the medicine cabinet, filled the cap to the top (beyond the fill line) midway on the cap; and - ULP-F did not administer Motegrity. R2's October 2025, MAR included: -furosemide 20 mg 2 tablets by mouth daily -polyethylene glycol (daily) take 17 grams (G) in 8 ounces of liquid twice daily -Motegrity (daily) take 1 tablet by mouth daily R2's medication pre-set up dose pack provided by the pharmacy did not include: -furosemide 20 mg 2 tablets by mouth daily R2's physician orders dated October 14, 2025, included the following -furosemide 20 mg 2 tablets by mouth daily -polyethylene glycol (daily) take 17 G in 8 ounces of liquid twice daily -Motegrity (daily) take 1 tablet by mouth daily marked "hold" Medication reconciliation by the surveyor identified the following: - Although R2's furosemide was on the MAR and on physician orders as 2 tablets every day, it was not included in the pre-set up dose pack from the pharmacy. - R2's polyethylene glycol was ordered as 17	01760		

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01760	Continued From page 81 grams which is marked in the cap with a fill line; however, ULP-F filled it to the top of the cap (beyond the fill line) giving the incorrect dose; and - Although R2's Motegrity was on hold per the physician orders, and was not in the pre-set up pack, it was listed on the MAR and was being signed off as if it was being given. On October 29, 2025, at 10:32 a.m., clinical nurse supervisor (CNS)-C stated R2's furosemide order was changed to as needed only; however, staff should not have just given the as needed dose without R2 requesting it. CNS-C stated staff should have filled the polyethylene glycol to the fill line and not to the top of the cap. In addition, CNS-C stated the Motegrity was in a separate bottle and should have been administered by the staff and it was not on hold. R3 R3 was admitted on May 31, 2025, and received assisted living services. On October 27, 2025, at 11:20 a.m., the surveyor observed ULP-D administering medications to R3. On October 28, 2025, at 8:07 a.m., the surveyor observed ULP-F administering medications to R3. R3's service plan signed June 2, 2025, indicated R3's services included assistance with dressing, grooming, bathing, transfers, medication set-up and monitoring, added on was medication administration.	01760		

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01760	Continued From page 82 On October 28, 2025, at 8:07 a.m., the surveyor observed ULP-F administering medications to R3. ULP-F removed the pre-set up pack from the pharmacy which included the following: - Meloxicam 15 mg 1 tablet by mouth every day - Metformin 500 mg 1 tablet by mouth twice a day with meals R3's October 2025, MAR included the following: - Metformin 500 mg, take 1 tablet by mouth twice daily scheduled at 8:00 a.m. and 8:00 p.m. R3's medication pre-set up dose pack provided by the pharmacy included: - Meloxicam 15 mg 1 tablet by mouth every day - Metformin 500 mg 1 tablet by mouth twice a day with meals in a morning pack and a evening pack The pre-set up dose pack did not include: - ferrous fumerate R3's unsigned, hospital Discharge Instructions (identified as the most current orders by CNS-C) included the following: - Meloxicam 15 mg 1 tablet by mouth every day - Metformin 500 mg 1 tablet by mouth twice a day with meals in a morning pack and a evening pack - Ferrous fumerate 9 mg iron 400 micrograms (mcg) tablet take one tablet before breakfast Medication reconciliation by the surveyor identified the following: - Meloxicam was included on the physician orders, and was in the dose pack, but was not identified on the MAR. - Metformin orders indicated with meals, the dose pack was set up for administration with meals; however, the MAR indicated and was signed off as being administered morning and bedtime. - Ferrous fumerate was ordered, but was not	01760		

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01760	Continued From page 83 included on the MAR or in the dose packs. On October 28, 2025, at 3:05 p.m., CNS-C stated the Meloxicam had been discontinued, the time needed to be changed on the MAR for the Metformin, ferrous fumerate should have been included on the MAR, should have been included in the dose packs, and should have been administered as ordered. R4 R4 was admitted on February 16, 2024, and received assisted living services. On October 27, 2025, at 11:22 a.m., the surveyor observed ULP-D administering medications to R4. R4's service plan dated February 16, 2025, indicated R4's services included medication set-up and medication administration. On October 27, 2025, at 11:22 a.m., the surveyor observed ULP-D administering medications to R4. ULP-D stated R4 prefers to take her morning medications at lunch time when she gets up. ULP-D removed the pre-set up pack from the pharmacy which included the following: - Calcium 600 mg 1 tablet by mouth twice a day R4's October 2025, MAR included the following: - calcium carbonate, take 1 capsule by mouth twice daily with meals scheduled at 12:00 p.m. and 8:00 p.m. - Myrbetriq 25 mg, take 1 tablet by mouth daily R4's medication pre-set up dose pack provided by the pharmacy included: - Calcium 600 mg 1 tablet by mouth twice a day	01760		

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01760	Continued From page 84 in the morning pack and bedtime pack. - The dose packs did not include Myrbetriq, folic acid, or ferrous sulfate. R4's physician orders dated October 20, 2025, included - calcium carbonate take 1 capsule by mouth twice daily with meals - Myrbetriq 25 mg - folic acid 1 mg take one tablet by mouth daily - ferrous sulfate 325 mg take one tablet by mouth every other day. Medication reconciliation by the surveyor identified the following: - Myrbetriq was ordered by the physician and was on the MAR being signed off by staff; however, the medication was not included in the pharmacy dose packs. - Calcium carbonate was ordered twice daily with meals but was being administered at 12:00 p.m. and bedtime - Folic acid and Ferrous sulfate was ordered, but was not included on the MAR or in the pharmacy dose packs. On October 29, 2025, at 10:04 a.m., CNS-C stated the calcium times needs to be changed to noon and evening. The Myrbetriq, folic acid, and ferrous sulfate should have been included in the medication dose packs. The folic acid and ferrous sulfate should have been on the MAR. R5 R5 was admitted on January 15, 2025, and received assisted living services. On October 27, 2025, at 11:32 a.m., the surveyor observed ULP-D administering medications to	01760		

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01760	Continued From page 85 R5. On October 28, 2025, at 8:12 a.m. ULP-F was observed administering medications to R5. R5's service plan dated February 1, 2025, indicated R5's services included medication administration. On October 28, 2025, at 8:12 a.m., the surveyor observed ULP-F administering medication to R5. ULP-F removed dose pack from the cabinet and set up medications for administration including the following: - sertraline 100 mg tablet, take 1.5 tablets daily R5's October 2025, MAR included the following: - sertraline 100 mg, take 1 tablet by mouth daily R5's medication pre-set up dose pack provided by the pharmacy included: - sertraline 100 mg tab, take 1.5 tablets daily R5's physician orders dated August 19, 2025, included: - sertraline 100 mg, take 1 tablet by mouth daily Medication reconciliation by the surveyor identified the sertraline was ordered as 100 mg, 1 tab daily; however, the pharmacy was dispensing and staff was administering 100 mg tablet 1.5 tablets daily On October 28, 2025, at 3:05 p.m., CNS-C stated she was unaware of the discrepancies between the physician orders, MARs and the dose packs, and all medications should be administered as ordered.	01760		

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01760	Continued From page 86 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 the medications were secured and locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the 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 of the residents). The findings include: On October 27, 2025, at 11:13 a.m. during continuous observation beginning at 11:13 a.m., the surveyor observed the following: - unlicensed personnel (ULP)-D had the keys in	01880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

(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
01880	Continued From page 87 the door of the office. In the office, was a file cabinet containing residents' medications. There was a medication refrigerator in the office that did not have a lock on it and contained Victoza (injectable diabetes medication). ULP-D removed the keys from the door, unlocked the cabinet, set up medications for administration, and left the room to administer the medications to R2. ULP-D left the keys in the medication cabinet and the door to the office open and entered R2's room. The office and the medication were not within ULP-D's line of site. - At 11:20 a.m., ULP-D set up R3's medications for administration, left the cabinet unlocked with the keys sitting on top of the cabinet, left the door to the room open, went to R3's room and administered the medications. The office and the medication were not within ULP-D's line of site. - At 11:22 a.m., ULP-D set up R4's medications for administration, left the office with the keys on the cabinet and the door open, went upstairs to administer the medications. R4 was sleeping and ULP-D returned downstairs to the medication room. The office and the medications were not within ULP-D's line of sight. - At 11:26 a.m., ULP-D went upstairs to ask R5 about his blood sugar. ULP-D left the keys to the cabinet and the door open. The office and the medications were not within ULP-D's line of sight. - At 11:27 a.m., ULP-D stated R4 was awake because she put on her call light. ULP-D removed the medication cup from R4's drawer, returned to R4's room upstairs leaving the keys on the cabinet and the door to the room open. The office and the medications were not within ULP-D's line of sight. - At 11:32 a.m., ULP-D returned to the office, set up R5's medication for administration and went upstairs to administer R5's medications. ULP-D	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38348	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE RESIDENTIAL LIVING	179 POTTOK LANE SHAKOPEE, MN 55379

(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
01880	Continued From page 88 left the keys on the cabinet and the door open. The office and the medications were not within ULP-D's line of sight. - at 11:39 a.m., ULP-D returned to the office. During the observations, R3 was in his room right next to the office, R2 came out and sat at a table doing crafts next to the open office door. Other staff were present at times in the common area outside of the office. On October 28, 2025, during continuous observation beginning at 7:39 a.m., the surveyor observed the following: - At 7:39 a.m., ULP-F washed hands and put on gloves. ULP-F unlocked the office door and left the keys in the door, went to the unlocked medication cabinet and removed R2's medications, set them up for administration and went to R2's room to administer their medications. ULP-F stated R2's inhaler was in her room. After administering oral medications, ULP-F removed an inhaler from R2's bedside stand and handed it to R2 who self administered the inhaler. ULP-F then placed the inhaler back into the drawer. ULP-F left the keys in the door to the room with the door open and the cabinet unlocked. The office and the medications were not within ULP-F's line of sight. - At 8:07 a.m., ULP-F removed R3's medications from the file cabinet and set up for administration. ULP-F then left the office with the cabinet unlocked and the door open to administer medications to R3. The office and the medications were not within ULP-F's line of sight. In R3's room, the surveyor observed an inhaler, Advil, Tums, eye drops and potassium on a table in R3's room. ULP-F stated R3 takes those medications independently. - At 8:12 a.m., ULP-F removed R5's medication	01880		

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	38348	A. BUILDING: _____ B. WING _____	10/29/2025

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01880	Continued From page 89 from the file cabinet and set them up for administration. ULP-F then went upstairs, leaving the office door open and the cabinet unlocked. The office and the medications were not within ULP-F's line of sight. R2's Individualized Medication Management Plan dated September 13, (last number of the year was illegible and appears to have been written over several times 2022, 2023, 2024), indicated R2 was not to have self-storage of medications and all medications should be locked in the medication cabinet. R3's Individualized Medication Management Plan dated June 1, 2025, indicated R3 was not to have self-storage of medications and all medications should be locked in the medication cabinet. On October 29, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-C stated staff should always lock the cabinet and should shut and lock the door whenever they are not present in the office. CNS-C stated she was unaware medications were being stored in R2 and R3's rooms, all medications should be locked in the cabinet in the office, and none of the residents were approved to self administer medications. The licensee's 7.11 Medication Storage dated January 1, 2024, indicated all medications would be securely locked and stored per manufacturer directions. Medications managed inside a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a locked drawer, cabinet, etc.	01880		

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	38348	A. BUILDING: _____ B. WING _____	10/29/2025

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01880	Continued From page 90 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	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 time sensitive medications were labeled with open and/or expiration dates for one of two residents with time sensitive medications (R5), and failed to ensure medications were stored with a full pharmacy label for three of four residents (R4, R5, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01890		

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	38348	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 91 On October 27, 2025, during a medication pass observation, the surveyor observed the following: - at 11:22 a.m., unlicensed personnel (ULP)-D removed R4's medication dosage pack from the cabinet. The pharmacy set up all the medications for each time in a single blister pack. On the back of the blister pack, was the identification of each pill in the back. On the top of the card, were the instructions for use. The back of the blister pack indicated vitamin D3 25 micrograms was included in the blister pack. The top of the blister pack the vitamin D3 was not included so there were no directions for use or prescription number associated with the medication. - at 11:32 a.m., ULP-D removed R5's prednisolone/moxifloxin/bromfenac acetate eye drop bottle. The medication did not have a box, prescription label, and was not labeled with the resident's name. ULP-D stated the drop was to be placed in the right eye. When the surveyor asked about the labeling of the eye drops, clinical nurse supervisor (CNS)-C stated there were instructions in the drawer for the eye drops from the surgeon. R5's Ophthalmology Post Operative Patient Instructions in the medication drawer indicated R5 was to take the prednisolone/moxifloxin/bromfenac acetate eye drop- Use one (1) drop, four (4) times per day in your operative eye for one (1) week following surgery, then: Use one (1) drop, two (2) times per day in your operative eye until the bottle is empty. On October 28, 2025, at 7:39 a.m., ULP-F was administering medications to R2. ULP-F removed a Symbicort inhaler from R2's bedside stand and gave to R2 to self-administer. There was not a	01890		

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01890	Continued From page 92 pharmacy label or an open date on the inhaler. On October 28, 2025, at 3:05 p.m., CNS-C stated all medications should have a pharmacy label or should have the resident's name, and all time sensitive medications should be marked with an open date. Symbicort's prescribing information dated June 2010, indicated the inhaler should be discarded when the labeled number of inhalations have been used, or within 3 months after removal from the foil pouch. The licensee's 7.11 Medication Storage policy dated January 1, 2024, indicated when medications are managed and stored by [licensee], medications will be kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940		

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01940	Continued From page 93 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual treatment management plan was developed for the licensee's two residents (R2, R5) receiving a 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:	01940		

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01940	Continued From page 94 R2 R2 was admitted on September 14, 2024, and received assisted living services. On October 27, 2025, at 11:13 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R2. ULP-D asked R2 what her blood sugar was and R2 reported it was 110. On October 28, 2025, at 7:39 a.m., the surveyor observed ULP-F administering medications to R2. ULP-F asked R2 what her blood sugar was this morning, and R2 had not checked it yet. ULP-F picked up a device and checked the continuous blood glucose monitor and informed R2 her blood sugar was 327. R2 self-administered a bolus dose via her insulin pump. R2's service plan dated September 13, 2025, indicated R2's services included assistance with dressing, hair care, bathing, stand by assistance getting in and out of the shower, medication administration, and medication administration. R2's service plan did not include blood glucose monitoring. R5 R5 was admitted on January 15, 2025, and received assisted living services. On October 27, 2025, at 11:26 a.m., the surveyor observed ULP-D ask R5 what his blood sugar was. R5 reported it was 104. ULP-D stated staff had been trained with the continuous blood glucose monitors, but also had been trained to use a standard blood glucose meter if the	01940		

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01940	Continued From page 95 continuous monitor failed. R5's service plan dated February 1, 2025, indicated R5's services included dressing, grooming, bathing, and medication administration. R5's service plan did not include blood glucose monitoring. On October 28, 2025, at 3:05 p.m., clinical nurse supervisor (CNS)-C stated R2 and R5's service plans should have included blood glucose monitoring. The licensee's undated, 7.05 Treatment & Therapy Management Plan policy indicated "For each resident at [licensee name] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced	02320		

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02320	Continued From page 96 by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice for the licensee's one resident (R2) with an inhaler, and for the licensee's one resident (R5) receiving eye drops and Victoza injections. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 28, 2025, at 7:39 a.m., the surveyor observed unlicensed personnel (ULP)-F set up R2's medications for administration and informed the surveyor that R2's inhaler was in her room. ULP-F administered oral medications and was going to leave the room when the surveyor asked about the inhaler. ULP-F then went to the bedside stand, removed the inhaler, and handed it to R2. R2 took one inhalation and handed the inhaler back to ULP-F, who placed it back into the drawer. ULP-F did not provide R2 with water to rinse her mouth and spit out, nor did she cue R2 to do it themselves. R2's MAR included Symbicort 160-4.5 inhale two puffs twice a day, rinse mouth after use.	02320		

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02320	Continued From page 97 On October 29, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-C staff were trained to have the resident rinse their mouth and spit it out after inhaler use. Symbicort's prescribing information dated June 2010, instructed "after inhalation, the patient should rinse the mouth with water without swallowing." R5 On October 27, 2025, at 11:32 a.m., ULP-D removed R5's prednisolone eye drop bottle and prednisolone/moxifloxin/bromfenac acetate eye drop bottle. ULP-D stated the prednisolone was for the left eye and the prednisolone/moxifloxin/bromfenac acetate eye drop was for the right eye. ULP-D had R5 lay down on the couch and ULP-D administered the eye drops. ULP-D did not shake either bottle prior to use. On October 28, 2025, at 8:12 a.m., ULP-F removed Victoza (injectable diabetes medication) from the drawer. ULP-F handed R5 the Victoza and the pen needle. R5 placed the pen needle onto the pen and injected the medication. R5 did not clean the port prior to placing the needle and did not clean his skin prior to injecting the medication. ULP-F did not cue R5 to clean the port or his skin. On October 29, 2025, at 10:47 a.m., CNS-C stated when administering insulin or Victoza, staff should always clean the port before putting on the needle and should clean the skin prior to injection. R5 should not have self-administered the Victoza; staff should have administered the Victoza using proper infection control measures.	02320		

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02320	Continued From page 98 CNS-C further stated staff should have shaken the eye drops prior to administration. R5's Ophthalmology Post Operative Patient Instructions dated October 17, 2025, in the medication drawer, instructed "shake gently before using". Prednisolone's undated, prescribing information instructed, "shake well before using". Victoza's prescribing information dated July 2023, instructions for use included, prior to placing the needle, patients were to "Wipe the rubber stopper with an alcohol swab." No further information 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

Establishment Info

NOBLE RESIDENTIAL LIVING
179 POTTOK LANE
Shakopee, MN 55379
Scott County
Parcel:

Phone:

License Info

License: HFID 38348

Risk:
License:
Expires on:
CFPM: Ahmed Abdi Bileh
CFPM #: 45306; Exp: 5/25/2028

Inspection Info

Report Number: F7963251067
Inspection Type: Full - Single
Date: 10/28/2025 Time: 12:15:38 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH HRD NURSE SURVEYOR STACY HAAG AND ESTABLISHMENT REPRESENTATIVE IDMAN BILEH. DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-HIGHLY SUSCEPTIBLE POPULATION RESTRICTIONS
-COLD HOLDING
-DISHWASHING
-HAND WASHING
-VOMIT/FECAL CLEAN UP

THIS IS A RESIDENTIAL HOME WITH NON-COMMERCIAL KITCHEN EQUIPMENT INCLUDING A DISHWASHER. FLOOR IS WOOD, CEILING SMOOTH PAINT, CABINETS WOOD AND COUNTERTOP SOLID SURFACE MARBLE. THEY DO SAME-DAY FOOD SERVICE.

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 F7963251067 from 10/28/2025

Idman Bileh

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

NOBLE RESIDENTIAL LIVING
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F7963251067
Inspection Type: Full
Date: 10/28/2025
Time: 12:15:38 PM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:**
Location: REFRIGERATOR at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: LUNCH MEAT**; Temperature Process:**
Location: REFRIGERATOR at 38 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

NOBLE RESIDENTIAL LIVING
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F7963251067
Inspection Type: Full
Date: 10/28/2025
Time: 12:15:38 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:**
Location: DISHWASHER RINSE **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No