Electronically Delivered

October 30, 2025

Licensee
Hills Crossing Senior Living
5307 Hills Crossing
Nisswa, MN 56468

RE: Project Number(s) SL27831016

Dear Licensee:

On October 16, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 16, 2025, and the follow-up survey completed on July 15, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

September 3, 2025

Licensee
Hills Crossing Senior Living
5307 Hills Crossing
Nisswa, MN 56468

RE: Project Number(s) SL27831016

Dear Licensee:

On July 15, 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 April 16, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 16, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 16, 2025, found not corrected at the time of the July 15, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on July 15, 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 $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 Benjamin J. Zwart at 651-201-3715.

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,

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	R 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#34822015-1 On July 17, 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 April 16, 2025. At the time of the survey, there were thirty (30) residents under the Assisted Living Dementia Care license. As a result of the follow-up survey, the following order was reissued.	{0 000}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet	{0 470}		

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
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{0 470}	Continued From page 1 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: Not reviewed during this survey.	{0 470}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	{0 480}		

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{0 480}	Continued From page 2 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	{0 480}		

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{0 480}	Continued From page 3 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 485}		
{0 680} SS=E	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	{0 680}		

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{0 680}	Continued From page 4 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on record review and interview, the	{0 775}		

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{0 775}	Continued From page 5 licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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: On July 17, 2025, the surveyor emailed licensed assisted living director (LALD)-B requesting documentation to support corrections for the 0775 tag pursuant to a survey completed on April 16, 2025. On July 17, 2025, LALD-B emailed a written plan of correction that indicated the following: Controlled Egress Door Locking System - Quote received and approved with the contractor. Parts were ordered and will get installed as soon as they arrive. This will be installed by July 31st, 2025, due to supply chain issues of getting parts. - Disaster Plan will be updated once the new door lock release is installed. This will be done by July 31st, 2025, or whenever the installation occurs. The program will add the below language and re-train staff once the installation is done. "If there is an emergency that occurs that would call for all doors to be released, the facility has a release button at the front entrance by the fire panel." Obstructed Egress The program is working with an architecture and engineering firm to determine if the exit sign can	{0 775}		

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{0 775}	Continued From page 6 be removed on the memory care deck egress. Unsure of correction dates, but the program has kept the Minnesota Department of Health in the loop on the progress. Smoke Alarms The program received a quote, and the quote was approved for replacement smoke alarms in resident sleeping rooms with a horn. Parts were ordered by the contractor and should arrive and be installed by 7/10/2025. Previous survey finding: On April 16, 2025, at 9:30 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed the following: Controlled Egress Door Locking System - Electromagnetic locks with keypads were installed on the emergency exit doors. During the facility tour interview, DM-D verified a controlled egress door locking sysytem was installed and stated a signal or switch was not installed that had the capability to break power to these door locks. Controlled egress door locking systems must comply with Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511. - On April 16, 2025, licensed assisted living director (LALD)-B and DM-D provided documents on the emergency evacuation procedures, the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on April 16, 2025, at approximately 12:00 p.m., LALD-B	{0 775}		

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{0 775}	Continued From page 7 verified these instructions were not included in the emergency plans. Obstructed Egress - An illuminated exit sign was installed above the door leading out to an exterior deck enclosed by railings for the dementia care building. Smoke Alarms Smoke alarms were not installed in resident sleeping rooms. Smoke detectors with strobe lights were installed in resident sleeping rooms. During the tour interview, DM-D stated they did not know if the smoke detectors were equipped with audible alarms in resident sleeping rooms. On May 1, 2025, the surveyor requested documentation and manufacturer specifications from LALD-B on the fire alarm system installed in resident sleeping rooms. On May 2, 2025, LALD-B emailed photos of installed strobe devices and a copy of the fire alarm system inspection report dated February 24, 2025. Manufacturer specifications for the fire alarm system were not provided. Record review of the available documentation indicated the resident sleeping room smoke detectors were not equipped with horn strobes or audible speaker bases that would provide an audible alarm in the event of a fire.	{0 775}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	{0 970}		

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{0 970}	Continued From page 8 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 970}		
{01760} SS=D	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: Not reviewed during this survey.	{01760}		
{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.	{01890}		

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{01890}	Continued From page 9 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01890}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01970}		
{02040} SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	{02040}		

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{02040}	Continued From page 10 by: Not reviewed during this survey.	{02040}		
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02310}		
{02320} SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02320}		

Electronically Delivered

May 16, 2025

Licensee
Hills Crossing Senior Living
5307 Hills Crossing
Nisswa, MN 56468

RE: Project Number(s) SL27831016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 16, 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27831016 On April 14, 2025, through April 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 29 residents; 29 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 470 SS=F	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 1 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 interview and record review, the licensee failed to post a daily work schedule at the beginning of each work shift. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470		

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0 470	Continued From page 2 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 held an assisted living with dementia care license and was licensed for a capacity of 30 residents, with a current census of 29 residents. During the entrance conference on April 14, 2025, at 10:50 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they had three shifts as follows: - day shift 6:00 a.m. to 2:30 p.m., with three unlicensed personnel (ULP) on the assisted living unit and two ULP on the dementia care unit; - evening shift 2:00 p.m. to 10:30 p.m., with two ULP on the assisted living unit and two ULP on the dementia care unit, with a possible bonus staff from 4:00 p.m. to 9:00 p.m.; and - night shift 10:00 p.m. to 6:00 a.m., with one ULP on the assisted living unit, one ULP on the dementia care unit, and one float ULP. The licensee's staffing plan dated April 10, 2025, noted a need of four staff. The undated licensee's Regular Staffing Plan posting noted: - a.m. shift 6:00 a.m. to 2:00 p.m. Sunday through Saturday. "CNAs (sic) [certified nursing assistants] / HHAs (sic) [home health aids] to provide direct care in ratio to residents based upon care level. 3 LPNs (sic) [licensed practical nurses] / Med [medication] Aides. 1 RN [registered nurse] present and/or on call. Life Enrichment Team. 2 Kitchen Staff.”;	0 470		

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0 470	Continued From page 3 - p.m. shift 2:00 p.m. to 10:00 p.m. Sunday through Saturday. "CNAs/HHAs to provide direct care in ratio to residents based upon care level. 3 LPNs/Med Aids. 2 Kitchen Staff (through evening meal). RN present or on call."; and - night shift 10:00 p.m. to 6:00 a.m. Sunday through Saturday. "CNAs/HHAs to provide direct care in ratio to residents based upon care level. 1 LPN or 1 RN present or on call." However, it did not include the total number of staff working each shift, the work schedules for each direct-care staff member, and the staff member's work assignment or work location. On April 15, 2025, at 9:30 a.m., executive director (ED)-C stated the posted schedule does not get changed from day to day and does not include the required content. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the	0 480		

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0 480	Continued From page 4 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of	0 485		

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0 485	Continued From page 6 Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to inform residents in advance of menu changes. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 16, 2025, at 12:10 p.m., the surveyor observed kitchen worker (KW)-H serving food in the assisted living dining room. When asked what was being served, KW-H stated she made stroganoff. KW-H stated this was not what was on the menu, but she made something easy because she did not have a helper. In addition, KW-H stated the resident's had not been informed of the change in advance. The posted menu showed chicken parmesan	0 485		

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0 485	Continued From page 7 alfredo. No further information was available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 680 SS=E	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 680		

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0 680	Continued From page 8 interview, the licensee failed to meet the minimum inspection and testing frequency for the emergency power generator as part of the emergency plan to ensure proper performance of the generator. 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 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 April 16, 2025, at 9:30 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the tour, a permanently installed generator was observed on the exterior of the facility. During the facility tour interview, DM-D stated the generator was inspected monthly and tested annually. After the tour, on April 16, 2025, DM-D provided generator inspection and testing records. Record review of the available documentation indicated the generator was inspected monthly and tested annually. During an interview on April 16, 2025, at approximately 11:45 a.m., licensed assisted living director (LALD)-B and DM-D verified the emergency power generator was part of the emergency plan. LALD-B and DM-D stated the licensee was not aware weekly generator inspections and monthly load tests were required and verified the frequency was not met. The minimum frequency of inspections, maintenance, and load tests are to meet the requirements for the emergency power generator as outlined under NFPA 110,	0 680		

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0 680	Continued From page 9 (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100 to ensure proper performance of the generator. TIME PERIOD FOR CORRECTION: Seven (7 days)	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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: On April 16, 2025, at 9:30 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed the following:	0 775		

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0 775	Continued From page 10 Controlled Egress Door Locking System - Electromagnetic locks with keypads were installed on the emergency exit doors. During the facility tour interview, DM-D verified a controlled egress door locking sysytem was installed and stated a signal or switch was not installed that had the capability to break power to these door locks. Controlled egress door locking systems must comply with Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511. - On April 16, 2025, licensed assisted living director (LALD)-B and DM-D provided documents on the emergency evacuation procedures, the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on April 16, 2025, at approximately 12:00 p.m., LALD-B verified these instructions were not included in the emergency plans. Obstructed Egress - An illuminated exit sign was installed above the door leading out to an exterior deck enclosed by railings for the dementia care building. - In the assisted living building, an illuminated exit sign was installed above the door at the end of the north hallway for an exterior courtyard. This courtyard was enclosed by a fence with a gate leading out to the main parking lot. The gate opening hardware was located on the non-exit side (outside the fence) and was not accessible to the building occupants to open the gate from the exit side. During the facility tour interview, DM-D verified the above listed obstructed egress observations.	0 775		

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0 775	Continued From page 11 Egress paths leading to the public way from a marked exit door shall comply with MSFC in Minnesota Rules Chapter 7511. Smoke Alarms Smoke alarms were not installed in resident sleeping rooms. Smoke detectors with strobe lights were installed in resident sleeping rooms. During the tour interview, DM-D stated they did not know if the smoke detectors were equipped with audible alarms in resident sleeping rooms. On May 1, 2025, the surveyor requested documentation and manufacturer specifications from LALD-B on the fire alarm system installed in resident sleeping rooms. On May 2, 2025, LALD-B emailed photos of installed strobe devices and a copy of the fire alarm system inspection report dated February 24, 2025. Manufacturer specifications for the fire alarm system were not provided. Record review of the available documentation indicated the resident sleeping room smoke detectors were not equipped with horn strobes or audible speaker bases that would provide an audible alarm in the event of a fire. Fire Door Maintenance The maintenance office and mechanical room fire doors were propped open. These rooms were unoccupied during the tour. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. During the tour interview, DM-D verified the above listed fire door observations. Clothes Dryer Maintenance In the assisted living laundry room, there was an accumulation of lint behind the clothes dryer, and the exhaust duct was partially disconnected, creating a fire hazard. During the tour interview,	0 775		

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0 775	Continued From page 12 DM-D verified the above listed observations. Physical Environment Maintenance In the assisted living mechanical room, there was a hole in the wall above the electrical panels. During the tour interview, DM-D verified the above listed observation. Extension Cord Use An orange extension cord was used to supply power in the assisted living shower room. Extension cords shall not be used as a substitute for permanent wiring. During the tour interview, DM-D verified the above listed extension cord observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.	0 970		

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	27831	A. BUILDING: _____ B. WING _____	04/16/2025

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0 970	Continued From page 13 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated Resident Agreement included the following clause under section 27B.: - "Insurance: In the event the Resident's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, you hereby waive: (a) all claims against Landlord and its representatives for any such loss or damage; and (b) all rights of subrogation of any insurance company carrying any insurance covering such damage or destruction." On April 16, 2025, at 9:50 a.m., licensed assisted living director (LALD)-B stated the same template was utilized for all contracts, and they were in the process of working with their lawyer after having the same issue at another site, to get this changed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 14 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 verify accuracy of prescriber orders when transcribing orders for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included hypertension, osteoporosis, and bilateral knee pain. On April 16, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-I provide	01760		

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01760	Continued From page 15 medication administration to R2. R2's Service Plan dated March 20, 2024, indicated R2 received services including assistance with dressing, grooming, showering, and medication administration. R2's prescriber orders dated April 10, 2025, included: - sodium chloride (Ocean Nasal Spray) 0.65% solution, two sprays, nasal, as needed. R2's April Med (Medication) Admin (Administration) Summary for April 2025, included: - Ocean Nasal Spray instill two sprays in both nostrils daily. On April 16, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the order was started twice daily on March 13, 2025, but had not been transcribed correctly. The licensee's undated Implementation of Medication Orders policy noted the registered nurse (RN) would add the order to the resident record in the appropriate place. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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	01890		

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01890	Continued From page 16 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of seven residents (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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 14, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. On April 14, 2025, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R4. R4's ibrance (a medication that works to put the brakes on cell growth in both healthy and cancer cells) was in a cardboard package inside a silicone type sleeve without a prescription label. ULP-F stated only one pack of the medication was kept in the medication cart at a time. In addition, R4's calcitonin-salmon nasal spray had 112 written on	01890		

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01890	Continued From page 17 the container. However, it lacked a prescription label. On April 15, 2025, at 11:05 a.m., the surveyor observed ULP-E administer medications to R5. ULP-E went to the medication refrigerator in the dementia care unit and removed a resealable plastic bag with five syringes in it. The bag was labeled "124 GAB". Each syringe contained 0.5 milliliters (ml) liquid. ULP-E stated she had set up the syringes with liquid gabapentin for R5. The bottle of the medication with the prescription label was in the same refrigerator. On April 16, 2025, at 10:15 a.m., CNS-A stated all medications should have an original prescription label on them, and stated the main package of ibrance with the prescription label on it was kept in her office due to the cost of the medication. The licensee's undated Central Storage of Medications policy noted medications that are centrally stored in the nurse's office or medication room would be kept in the original containers with the original prescription label. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other	01970		

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01970	Continued From page 18 information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R2) who received treatments managed be the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included hypertension, osteoporosis, and bilateral knee pain. R2's record lacked an order for compression stockings. On April 16, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-I provide medication administration to R2. R2's Service Plan dated March 20, 2024, indicated R2 received services including assistance with dressing, grooming, showering, compression stockings, and medication administration.	01970		

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01970	Continued From page 19 On April 16, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated R2's record contained an order dated November 27, 2023, to measure for compression stockings, but lacked a current order for the compression stockings. The licensee's undated Content of Medication Prescriptions and Treatment or Therapy Orders policy noted an order for a treatment must be current. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to mitigate a safety risk identified in the facility hazard vulnerability assessment of the physical environment.	02040		

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02040	Continued From page 20 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 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). Findings include: On April 16, 2025, assisted living director (LALD)-B provided a hazard vulnerability assessment tool. Chemical usage was identified as a risk and the mitigation plan directed employees to store all chemicals in the locked laundry room or locked cupboards. On April 16, 2025, at 9:30 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed chemicals were stored in cabinets under the bathroom sinks in resident rooms 121 and 125 in the dementia care unit. The doors to these rooms were open at the time of the tour. During the facility tour interview, DM-D verified the chemical storage observations. TIME PERIOD FOR CORRECTION: Two (2) days	02040		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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02310	Continued From page 21 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3), whose consumer bedrail was removed without an assessment by the registered nurse (RN). In addition, the licensee failed to ensure liquid medication was set up by a nurse, pharmacy, or authorized prescriber for later administration by the facility staff, and failed to ensure documentation of medication setup included all the required content for one of one resident (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, 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: CONSUMER RAIL REMOVED R3's diagnosis included Alzheimer's disease, depression, osteoarthritis, weakness, and hypertension. R3's Service Plan dated November 1, 2024, indicated R3 received services including assistance with dressing, grooming, and medication administration.	02310		

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02310	Continued From page 22 R3's Assessment dated February 17, 2025, identified as a 90 day assessment, noted R3 required staff assistance from a lying position, and noted R3 had bilateral half bedrails, recommended for assistance with transfers, turning and repositioning in bed, and fall prevention. R3's record lacked evidence the facility assessed the resident prior to the removal of the assistive device. On April 16, 2025, at 10:22 a.m., clinical nurse supervisor (CNS)-A stated R3 had not been assessed before he received a new bed without bedrails on it and the old bed was removed. MEDICATION SETUP FOR LATER ADMINISTRATION R5's diagnoses included Graves disease and dementia. On April 15, 2025, at 11:10 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R5. ULP-E went to the medication refrigerator in the dementia care unit and removed a resealable plastic bag with five syringes in it. The bag was labeled "124 GAB". Each syringe contained 0.5 milliliters (ml) liquid. ULP-E stated she had set up the syringes with liquid gabapentin for R5. ULP-E stated GAB was for gabapentin. In addition, ULP-E stated she had filled the five syringes in the bag herself with 0.5 milliliters (ml) medication as she was trained to do by a previous nurse. ULP-E stated she did not document the medication setup. R5's Service Plan dated November 1, 2024, indicated R5 received services including assistance with dressing, grooming, and	02310		

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02310	Continued From page 23 medication administration. On April 15, 2025, at 11:27 a.m., CNS-A stated she was aware ULP-E was setting up the liquid gabapentin for R5 to be administered at a later time, and this was not being documented. CNS-A stated they had a pharmacist come out and they said it was ok for ULP to do this medication setup. The licensee's undated Documentation of Medication Assistance policy noted a licensed nurse would set up medications in dosage boxes for the resident. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in	02320		

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02320	Continued From page 24 sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three unlicensed personnel/ULP (ULP-F, ULP-G) followed appropriate medication administration procedures. 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: R3's diagnoses included Alzheimer's disease, depression, and hypertension. R3's Service Plan dated November 1, 2024, indicated R3 received services including assistance with dressing, grooming, and medication administration. R3's prescriber orders dated March 5, 2025, included Calmoseptine ointment, apply topically two times a day to the buttocks. On April 15, 2025, at 8:05 a.m., the surveyor observed ULP-F administer oral medications to R3 in the dining room. ULP-F stated ULP-G had	02320		

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02320	Continued From page 25 already applied the Calmoseptine ointment when she provided morning cares to R3. ULP-F stated she had not provided the ointment but signed off as administering it. At this time, ULP-G stated she applied the ointment that had been left in R3's room from a previous shift with the name of the medication written on it. ULP-F and ULP-G were hired on October 1, 2015, and December 27, 2024. respectively, to provide direct care services to residents of the facility. ULP-F's record contained an annual competency review dated August 9, 2018, which indicated she had passed medication administration. ULP-G's record contained a Med (Medication) Skills form dated February 13, 2023, which indicated she had passed. On April 15, 2025, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated staff had been given an option of keeping this ointment in the medication cart or in a cupboard in the nursing office, and they opted for the medication cart. CNS-A stated the medication should be signed off by the person who administered the medication. The licensee's undated Documentation of Medication Services on the MAR (Medication Administration Record) policy noted staff would document medication administration immediately after completing the task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *04/14/25*
Time: 12:09:37
Report: 1017251062

Food and Beverage Establishment Inspection Report

Location:
Hills Crossing Senior Living
5307 Hills Crossing
Nisswa, MN56468
Crow Wing County, 18

Establishment Info:
ID #: 0038532
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189615605
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

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

3-302.13 ***** Priority 1 *****

MN Rule 4626.0245 Discontinue use of unpasteurized eggs or egg products in the preparation of food such as Caesar salad, hollandaise or bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages, and other foods that are not cooked as specified in 4626.0340.

UNPASTEURIZED UNDER COOKED EGGS ARE BEING OFFERED TO PATIENTS FOR BREAKFAST, PROVIDE PASTEURIZED EGGS.

Comply By: 04/14/25

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

FOOD (YOGURT AND MILK) LOCATED IN UNDER COUNTER COOLER IN MEMORY CARE SERVING KITCHEN MEASURED 50 degrees F. FOOD WAS DISCARDED DURING INSPECTION.

Comply By: 04/14/25

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

TEST STRIPS FOR QUATERNARY AMMONIA HAVE EXPIRED, REPLACE WITH NEW STRIPS.

Comply By: 04/29/25

4-300 Equipment Numbers and Capacities

4-301.14

MN Rule 4626.0690 Provide ventilation hood systems in sufficient number and capacity to prevent grease or condensation from collecting on walls and ceilings.

CEILING TILE IS MISSING LEFT OF OVEN, REPLACE CEILING TILE.

Comply By: 04/21/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COOLER LOCATED IN MEMORY CARE UNIT WAS NOT MAINTAINING TEMPERATURE, REPAIR COOLER.

Comply By: 04/14/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CLEAN BEHIND OVEN ON COOKING LINE AND CLEAN AIR DUCTS.

Comply By: 04/21/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET MEMORY CARE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET DINING ROOM
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET KITCHEN
Violation Issued: No

Hot Water: = at 163 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: SALAD LOCATED IN TWO DOOR UPRIGHT COOLER

Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: CHICKEN LOCATED IN TWO DOOR UPRIGHT
Violation Issued: No

Type: Full
Date: *04/14/25*
Time: 12:09:37
Report: 1017251062
Hills Crossing Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 185 Degrees Fahrenheit - Location: CARROTS LOCATED IN POT ON STOVE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: GRAVY LOCATED IN POT ON STOVE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 185 Degrees Fahrenheit - Location: MASHED POTATO LOCATED IN POT ON STOVE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 50 Degrees Fahrenheit - Location: YOGURT UNDER COUNTER COOLER
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	3

DISCUSSION

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1017251062 of 04/14/25.

Certified Food Protection Manager: RACHEL ELIZABETH PETERSON

Certification Number: FM 123472 Expires: 04/15/27

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017251062

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 04/14/25
Time In 12:09:37
Time Out

	Address	City/State	Zip Code	Telephone
Hills Crossing Senior Living	5307 Hills Crossing	Nisswa, MN	56468	2189615605

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038532		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight	
2	IN OUT N/A	Certified food protection manager, duties	
Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting	
4	IN OUT	Proper use of reporting, restriction & exclusion	
5	IN OUT	Procedures for responding to vomiting & diarrheal events	
Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use	
7	IN OUT N/O	No discharge from eyes, nose, & mouth	
Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed	
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed	
10	IN OUT	Adequate handwashing sinks supplied/accessible	
Approved Source			
11	IN OUT	Food obtained from approved source	
12	IN OUT N/A N/O	Food received at proper temperature	
13	IN OUT	Food in good condition, safe, & unadulterated	
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction	
Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected	
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized	
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food	

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature	
19	IN OUT N/A N/O	Proper reheating procedures for hot holding	
20	IN OUT N/A N/O	Proper cooling time & temperature	
21	IN OUT N/A N/O	Proper hot holding temperatures	
22	IN OUT N/A	Proper cold holding temperatures	
23	IN OUT N/A N/O	Proper date marking & disposition	
24	IN OUT N/A N/O	Time as a public health control: procedures & records	
Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food	
Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered	
Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used	
28	IN OUT	Toxic substances properly identified, stored, & used	
Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP	

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56	X	Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 04/15/25

Inspector (Signature)