



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 23, 2026

Licensee

Norbella Senior Living Prior Lake
4285 Fountain Hill Drive Northeast
Prior Lake, MN 55372

RE: Project Number(s) SL37315016

Dear Licensee:

On May 27, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 7, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 7, 2026 survey.

The Department of Health 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 January 7, 2026, found not corrected at the time of the May 27, 2026, follow-up survey and/or subject to penalty assessment are as follows:

1290 - Background Studies Required - 144g.60 Subdivision 1 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on May 27, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/27/2026
NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
(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 SL24718017-2 On May 26, 2026, through May 27, 2026, the Minnesota Department of Health conducted a follow-up survey for the above provider to follow-up on orders issued pursuant to a license order follow up completed on January 7, 2026, and April, 8, 2026. At the time of the survey, there were 35 residents; 35 receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were issued and/or reissued: 1290.	{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.		
{0 700} SS=E	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or	{0 700}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 700}	Continued From page 1 electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	{0 700}	Not reviewed during this survey.		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}			
{01060} SS=D	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;	{01060}			

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{01060}	Continued From page 2 (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 This MN Requirement is not met as evidenced by:	{01060}			
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	{01290}	Not reviewed during this survey.		

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{01290}	Continued From page 3 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-R). This had the potential to affect all residents living in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-R was hired on April 23, 2026, and provided direct care services for the licensee's residents.	{01290}			

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{01290}	Continued From page 4 The licensee's staff scheduled indicated ULP-R had worked unsupervised on May 15, 20, 21, and 23, 2026. The licensee's NETStudy roster indicated ULP-R was affiliated on May 26, 2026, after the surveyor entered and requested NETStudy roster. ULP-R had a Minnesota Department of Human Services Clearance Letter for Health Facility Identification (HFID) 31249. On May 27, 2026, at 3:23 p.m., licensed assisted living director (LALD)-A stated the other facility was owned by the same company. When ULP-R was hired, human resources affiliated ULP-R to the wrong facility. No further information was provided.	{01290}			
{01880} SS=E	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:	{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	{01890}			
			Not reviewed during this survey.		

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{01890}	Continued From page 5 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey.		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}			
{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:	{02320}			

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{02320}	Continued From page 6	{02320}	Not reviewed during this survey.		



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Electronically Delivered

April 21, 2026

Licensee

Norbella Senior Living Prior Lake
4285 Fountain Hill Drive Ne
Prior Lake, MN 55372

RE: Project Number(s) SL37315016

Dear Licensee:

On April 8, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 7, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 7, 2026 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 7, 2026, found not corrected at the time of the April 8, 2026, follow-up survey and/or subject to penalty assessment are as follows:

1290-Background Studies Required-144g.60 Subdivision 1 - \$500.00

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - \$1,000.00

1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5

2320-Appropriate Care And Services-144g.91 Subd. 4 (b)

The details of the violations noted at the time of this follow-up survey completed on April 8, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

Also, at the time of this follow-up survey completed on April 8, 2026, we identified the following violation(s):

0700-Resident Record-144g.43 Subdivision 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37315016-1 On April 8, 2026, the Minnesota Department of Health conducted a deck follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on January 7, 2026. As a result of the follow-up survey, the following orders were issued and/or reissued: 0700, 1290, 1760, 1960, 2320.	{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.		
0 700 SS=E	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or	0 700			

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0 700	Continued From page 1 electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of electronic records. 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 April 8, 2026, at 11:41 a.m., unlicensed personnel (ULP)-O checked R5's electronic medication administration record (MAR) on a tablet sitting on a medication cart in a common area. ULP-O removed R5's blood glucose meter and went down the hallway to R5's room, leaving the screen open and visible to staff, residents, and visitors. R5's MAR was visible which included her medical and personal information. ULP-O checked her blood glucose and returned to the medication cart. ULP-O set up oral medications	0 700			

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0 700	Continued From page 2 and insulin, returned to R5's room, and again left the screen open to R5's MAR. ULP-O administered the medications and returned to the medication cart to document administration. On April 8, 2026, at 11:53 a.m., ULP-O checked R2's MAR on a tablet sitting on the medication cart in a common area. ULP-O went down the hallway to R2's room, leaving the screen open and visible to staff, residents, and visitors. R2's MAR was visible which included her medical and personal information. ULP-O checked her blood glucose and returned to the medication cart. On April 8, 2026, at 12:04 p.m., ULP-N checked R7's electronic MAR on a tablet sitting on the medication cart in a common area. ULP-N removed R7's blood glucose meter, went down the hallway to R7's room, leaving the screen open and visible to staff, residents, and visitors. R7's MAR was visible which included her medical and personal information. ULP-N checked her blood glucose and returned to the medication cart. ULP-N set up R7's insulin, returned to R7's room, and again left the screen open to R7's MAR. ULP-N administered the insulin and returned to the medication cart to document administration. On April 8, 2026, at 12:08 p.m., the surveyor entered the assisted living area of the facility and observed the two medication carts in a common area visible to staff, residents, and visitors. On one of the medication carts, a tablet screen was open to R2's MAR which included R2's medical and personal information. No staff were present in the area. On April 8, 2026, at 12:10 p.m., ULP-O returned to the medication cart, retrieved R2's insulin pen and set up for administration. ULP-O went down	0 700			

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0 700	Continued From page 3 the hallway to R2's room, leaving the screen open and visible to staff, residents, and visitors. R2's MAR was visible which included her medical and personal information. ULP-O administered the insulin and returned to the medication cart. On April 8, 2026, at 2:02 p.m., clinical nurse supervisor (CNS)-B stated staff should secure the resident's records when walking away from the cart. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700	Not reviewed during this survey.		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}			
{01060} SS=D	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;	{01060}			

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{01060}	Continued From page 4 (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 This MN Requirement is not met as evidenced by:	{01060}			
{01290} SS=F	144G.60 Subdivision 1 Background studies required	{01290}	Not reviewed during this survey.		

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{01290}	Continued From page 5 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of two employees (director of environmental services (DES)-J, director of culinary services (DCS)-Q). This had the potential to affect all residents living in the assisted living 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:	{01290}			

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{01290}	Continued From page 6 DES-J was hired on May 22, 2025, to provide maintenance services for the licensee and their residents. The licensee's NETStudy roster indicated DES-J was affiliated on April 8, 2026, after surveyor entered and requested NETStudy roster to include DES-J's affiliation. DCS-Q was hired on December 1, 2025, to provide dietary services to the facility's residents. The licensee's NETStudy roster indicated DES-J was affiliated on April 8, 2026, after the surveyor entered and requested NETStudy roster to include DES-J's affiliation. On April 8, 2026, at 1:42 p.m., licensed assisted living director (LALD)-A stated DCS-Q and DES-J could have unsupervised contact with the residents. They work at sister facilities but were just affiliated to this license today, and should have been affiliated to each facility they worked at. No further information was provided.	{01290}			
{01760} SS=G	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 7 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 one of one resident (R5) reviewed with insulin administration. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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: On April 8, 2026, at 11:41 a.m., the surveyor observed unlicensed personnel (ULP)-O checking R5's blood glucose (BG) and administering insulin to R5. R5 was admitted on December 24, 2024, with diagnosis including diabetes. R5's physician orders dated March 9, 2026, included Novolog (fast acting) insulin 10 units subcutaneously three times daily with meals. Hold if blood sugar is less than 100. R5's April 2026, medication administration record (MAR) included:	{01760}			

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{01760}	Continued From page 8 - Blood sugar checks at 7:45 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. "NOTIFY NURSING IF BLOOD SUGAR IS LESS THAN 70 OR ABOVE 400". - Novolog Flexpen (insulin) inject 10 units three times a day before meals at 7:45 a.m., 11:45 a.m., and 4:45 p.m., hold for blood sugar less than 100. - April 3, 2026, at 7:45 a.m. R5's BG was 93; although R5's blood sugar was less than 100, the Novolog insulin was administered. R5's subsequent BG readings were at 11:45 a.m. with a result of 81 and insulin was held for that dose, at 8:00 p.m. BG was 94. - On April 4, 2026, at 4:45 p.m., R5's BG was 74; although R5's blood sugar was less than 100, the Novolog insulin was administered; subsequent BG at 8:00 p.m. was 54; although R5's blood sugar was less than 70, the nurse was not notified and R5's long acting Lantus insulin was administered. - On April 8, 2026, at 7:45 a.m., R5's BG was 93; although R5's blood sugar was less than 100, the Novolog insulin was administered. R5's progress notes for April 2026, the did not include documentation of the above noted results. On April 8, 2026, at 2:32 p.m., clinical nurse supervisor (CNS)-B stated staff should have held the insulin when blood sugars were less than 100, per physician orders. The licensee's Medications and Treatments Policy dated December 2025, section Medication Management Services Provided by Unlicensed Personnel indicated "The ULP will follow the six rights of medication administration". No further information was provided.	{01760}			

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{01880} SS=E	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:		{01880}	Not reviewed during this survey.	
{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:		{01890}		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided		{01960}		

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{01960}	Continued From page 10 to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments were administered as ordered for all two of two residents (R5, R7) reviewed with blood glucose monitoring. 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: R5 On April 8, 2026, at 11:41 a.m., the surveyor observed unlicensed personnel (ULP)-O checking R5's blood glucose (BG) and administering insulin to R5. R5 was admitted on December 24, 2024, with diagnosis including diabetes. R5's physician orders dated March 9, 2026, included Novolog (fast acting) insulin 10 units subcutaneously three times daily with meals. Hold if blood sugar is less than 100. R5's physician orders dated February 9, 2026, included blood glucose checks four times a day. Notify nurse if less than 70 or more than 400.	{01960}			

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{01960}	Continued From page 11 R5's April 2026, medication administration record (MAR) included: - Blood sugar checks at 7:45 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. "NOTIFY NURSING IF BLOOD SUGAR IS LESS THAN 70 OR ABOVE 400". - Novolog Flexpen (insulin) inject 10 units three times a day before meals at 7:45 a.m., 11:45 a.m., and 4:45 p.m., hold for blood sugar less than 100. - On April 4, 2026, at 8:00 p.m., was 54; although R5's blood sugar was less than 70, the nurse was not notified and R5's long acting Lantus insulin was administered. R5's progress notes for April 2026, did not include documentation the nurse had been notified of the low blood sugar. R7 On April 8, 2026, at 12:04 p.m., the surveyor observed ULP-N checking R7's blood glucose and administering insulin. R7 was admitted on October 24, 2024, with diagnoses including type 1 diabetes, congestive heart failure, mild cognitive impairment, chronic kidney disease, and depression. R7 resided in the secured memory care unit of the facility. R7's physician orders dated October 26, 2025, included monitor blood sugar and report to nurse if the blood sugar is less than 80 or greater than 450. R7's physician orders dated December 29, 2025, included lispro insulin, administer 10 units prior to breakfast, lunch, and dinner. Do not hold short acting insulin unless blood sugar less than 60 and	{01960}			

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{01960}	Continued From page 12 symptomatic. If short acting needs to be held prior to a meal, contact provider. May also administer short acting directly after the meal and recheck his blood sugar 30-60 minutes after administration of insulin. R7's physician orders dated October 26, 2025, included: - Freestyle Libre use to check blood sugar five times a day - Accu-check use if Freestyle Libre is not working to check blood sugar five times a day R7's April 2026, Medication Administration Record (MAR) included the following: - Monitor Blood Sugar - obtain blood sugar reading. Report to nurse if blood sugar is lower than 80 or greater than 450. - Insulin lispro injection (Humalog Kwikpen) - inject 10 units subcutaneously three times daily before meals. Hold only for blood sugar less than 60. - On April 1, 2026, at 4:45 p.m., R7's blood sugar was 79, although R7's blood sugar was less than 80, the nurse was not notified; and - On April 5, 2026, at 11:45 a.m., R7's blood sugar was 78, although R7's blood sugar was less than 80, the nurse was not notified. On April 8, 2026, at 2:32 p.m., clinical nurse supervisor (CNS)-B stated staff should have notified the nurse when blood sugars were outside of the parameters specified and that should be documented in the progress notes. R7's progress notes dated April 2026, did not include the above noted blood sugars. The licensee's Medications and Treatments	{01960}			

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{01960}	Continued From page 13 Policy dated December 2025, section Medication Management Services Provided by Unlicensed Personnel indicated the ULP will follow the six rights of medication administration. No further information was provided.	{01960}			
{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: Based on observation, interview, and record review, licensee failed to ensure two of two unlicensed personnel (ULP-O, ULP-N) administered medications according to policy and accepted standards of practice during insulin administration. 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:	{02320}			

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{02320}	Continued From page 14 ULP-O On April 8, 2026, at 12:10 p.m., unlicensed personnel (ULP)-O removed R2's Humalog Kwikpen from the medication cart, removed the cap, cleaned the port, placed the needle on the pen, and dialed the pen to 10 units. ULP-O did not prime the insulin pen. ULP-O went to R2's room and administered the insulin. R5 On April 8, 2026, at 11:41 a.m., ULP-O removed R5's Novolog insulin pen from the medication cart, removed the cap, cleaned the port, placed the needle on the pen, and dialed the pen to 10 units. ULP-O did not prime the insulin pen. ULP-O went to R5's room and administered the insulin. ULP-N On April 8, 2026, at 12:04 p.m., ULP-N removed R7's lispro insulin from the medication cart, removed the cap, and placed the needle on the pen. ULP-N did not clean the port prior to attaching the needle. ULP-N primed the pen, dialed to the correct dose and administered the insulin. On April 8, 2026, at 12:06 p.m., ULP-N stated she was unaware she needed to clean the port prior to putting on the needle. On April 8, 2026, at 2:02 p.m., clinical nurse supervisor (CNS)-B stated staff are trained to clean the port prior to putting on the needle and prime the pen. Staff should have administered as trained. The licensee's Skill: Assisting with Insulin Administration procedure dated February 2021,	{02320}			

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{02320}	Continued From page 15 included: - Remove Pen Cap and clean rubber seal with alcohol swab for 15 seconds prior to -Securely attach needle tip by screwing on to insulin pen; and - Priming the insulin pen. The insulin pen is to be primed prior to each use to prevent the collection of air in the insulin reservoir. · Dial 2 units by turning the dose selector clockwise · With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. The NovoLog injection FlexPen instructions for use dated revised February 2015, noted: A. Pull off the pen cap, wipe the rubber stopper with an alcohol swab. B. Attach the needle E. Turn the dose selector to select 2 units F: Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. Humalog KwikPen instructions (lispro) for use dated revised March 2013, noted: Step 1: Remove the insulin cap and wipe the rubber seal with an alcohol swab Step 5: Turn the Dose Knob to select 2 units. Step 6: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 7: Hold your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. A stream of insulin should	{02320}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/08/2026
NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
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{02320}	Continued From page 16 be seen from the needle. Step 11: Put your thumb on the Dose Knob and push the Dose Knob in until it stops. Hold the Dose Knob in and slowly count to 5. Step 12: Pull the Needle out of your skin. No further information was provided.	{02320}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 20, 2026

Licensee

Norbella Senior Living Prior Lake
4285 Fountain Hill Drive Northeast
Prior Lake, MN 55372

RE: Project Number(s) SL37315016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 7, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - \$1,000.00

St - 0 - 2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,000.00**. 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/Bm5uQEpHV>**. 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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
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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: SL37315016-0 On January 5, 2026, through January 7, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 36 residents; 36 receiving services under the Assisted Living Facility license. 1290: An immediate correction order was issued on January 5, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I. 2320: An immediate correction order was issued on January 7, 2026, at a level 3/Isolated (G). The licensee took immediate action; however, the scope and level remain at G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/07/2026
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0 510	Continued From page 1	0 510			
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 ensure compliance with accepted health care, medical, and nursing standards for infection control related to the disposal of sharps for one of three unlicensed personnel (ULP-G). This had the potential to affect all staff, residents, visitors, and the public. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 6, 2025, the surveyor observed ULP-G checking blood glucose for R7. ULP-G put	0 510			

Minnesota Department of Health

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0 510	Continued From page 2 on gloves, cleaned R7's finger, used a safety lancet to prick the finger, and attempted to obtain blood to put on the strip but was unsuccessful. ULP-G placed the lancet device in the garbage can in the resident's room. ULP-G obtained supplies and following the same process using a safety lancet, pricked R7's finger, obtained an adequate amount of blood and completed the blood glucose test. ULP-G then threw the lancet device into R7's trash, removed the gloves and exited the room. On January 7, 2026, at 1:09 p.m., clinical nurse supervisor (CNS)-B stated staff should throw all sharps, including lancet devices, into the sharps container and not in the trash. The licensee's Blood Glucose Test policy dated June 2021, indicated staff were to dispose of used fingerstick devices and lancets at the point of use in an approved sharps container. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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 ensure the physical environment of the facility was maintained in	0 775			

Minnesota Department of Health

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0 775	Continued From page 3 compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a client ' s health or safety but had the potential to have harmed a client ' s health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 6, 2026. for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
01060 SS=D	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;	01060			

Minnesota Department of Health

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01060	Continued From page 4 (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 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, designated representative, and ombudsman for an emergency relocation for one of one resident (R7). This practice resulted in a level two violation (a	01060			

Minnesota Department of Health

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01060	Continued From page 5 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: R7 was admitted on October 24, 2024, with diagnoses including type 1 diabetes, congestive heart failure, mild cognitive impairment, chronic kidney disease, and depression. R7 resided in the secured memory care unit of the facility. On January 6, 2026, at 11:42 a.m., the surveyor observed unlicensed personnel (ULP)-G checking R7's blood glucose and administering insulin. R7's progress notes included the following; - On August 13, 2025, at 5:15 p.m., staff had checked R7's blood glucose and it was greater than 600, reading high on the blood glucose meter. Staff contact the on-call nurse who instructed to call 911 and have R7 sent to the hospital. - On August 13, 2025, at 11:23 p.m., the nurse was notified R7 had been admitted to the hospital. - R7 returned from the hospital on August 19, 2025, (six days later). R7's record lacked evidence of 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	01060			

Minnesota Department of Health

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01060	Continued From page 6 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. The record lacked evidence the above written notice had been provided as soon as practicable to the the resident, legal representative, designated representative, and case manager. Their was no evidence the ombudsman had been notified when he was in the hospital and had not returned to the facility within four days. On January 7, 2026, at 2:29 p.m., clinical nurse supervisor (CNS)-B stated the emergency transfer form and the required notifications had been missed for R7's hospitalization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290			

Minnesota Department of Health

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01290	Continued From page 7 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted through Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-D). This resulted in an immediate correction order on January 5, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on June 24, 2025, and provided direct care services to the facility's residents.	01290			

Minnesota Department of Health

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01290	Continued From page 8 The licensee's NETStudy roster indicated ULP-D had a background study completed on June 19, 2025, and was separated from employment on August 12, 2025. ULP-D's time card indicated they recently worked the following dates: - December 2, 3, 4, 5, 6, 7, 9, 11, 13, 16, 17, 18, 22, 23, 25, 27, 29, and 30, 2025 - January 1, 3, and 4, 2026 On January 5, 2026, at 2:03 p.m., licensed assisted living director (LALD)-A stated ULP-D had a death in the family, planned to leave the country, and put in her notice. LALD-A stated he separated her from employment at that time; however, within a few days, ULP-D decided to continue working for the licensee as a casual employee and corporate did not initiate a new background study. At 2:30 p.m., LALD-A further stated when ULP-D works, she is unsupervised. The licensee's Background Check Review Process dated July 1, 2025, indicated "No one without an MNDHS [Minnesota DHS] Netstudy Clearance Letter will be allowed to begin employment." No further information provided. Time period for correction: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remain at I.	01290			
01760 SS=H	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
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01760	Continued From page 9 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 three residents (R7, R2, R5) reviewed with insulin administration and one of three residents (R4) with other medications. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a 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: R7 R7 was admitted on October 24, 2024, with diagnoses including type 1 diabetes, congestive heart failure, mild cognitive impairment, chronic kidney disease, and depression. R7 resided in	01760			

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NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
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01760	Continued From page 10 the memory care unit of the facility. On January 6, 2026, at 11:42 a.m., the surveyor observed unlicensed personnel (ULP)-G check R7's blood glucose using his Freestyle Libre continuous monitor and the reading was "HI". ULP-G then retrieved the fingerstick blood glucose monitor and checked R7's blood glucose with a result of 503. ULP-G notified licensed practical nurse (LPN)-H. LPN-H instructed ULP-G to administer insulin as ordered and encourage R7 to walk and drink water. R7's Medication Administration Record (MAR) included the following: - Monitor Blood Sugar - obtain blood sugar reading. Report to nurse if blood sugar is lower than 80 or greater than 450. If the Freestyle sensor reads "high", repeat blood sugar by fingerstick method. - Insulin lispro injection (Humalog Kwikpen) - inject 10 units subcutaneously three times daily before meals. Hold only for blood sugar less than 60. Please note: short acting insulin is meant to cover meals and should be administered approximately 15 minutes before resident eats. hold short acting insulin only if blood sugar is less than 60 and resident is symptomatic. If short acting needs to be held prior to a meal, contact the nurse. May also administer short acting directly after the meal and recheck his blood sugar 30-60 minutes after insulin administration. - Lantus Solostar injection - inject 10 units subcutaneously at bedtime. R7's physician orders dated December 29, 2025 indicated lispro insulin administer 10 units prior to breakfast, lunch, and dinner. Do not hold short acting insulin unless blood sugar less than 60 and symptomatic. If short acting needs to be held	01760			

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01760	Continued From page 11 prior to a meal, contact provider. May also administer short acting directly after the meal and recheck his blood sugar 30-60 minutes after administration of insulin, R7's physician orders dated October 26, 2025, included: - Lantus Solostar injection - inject 10 units subcutaneously at bedtime. - Freestyle Libre use to check blood sugar five times a day - Accu-check use if Freestyle Libre is not working to check blood sugar five times a day On January 6, 2026, at 11:56 a.m., ULP-G removed R7's Lantus insulin pen, cleansed port, primed the pen, and dialed the dose to 10 units. ULP-G then locked the cart, closed the screen and began walking to R7's room. When ULP-G reached R7's door, the surveyor intervened and informed ULP-G she had the wrong insulin. ULP-G returned to the cart, removed the other Lantus insulin pen (which was empty) and then put it back in the cart. The lispro insulin was sitting next to the Lantus. ULP-G went to the refrigerator to get another insulin pen stated the pen was empty (referring to the empty Lantus pen) and the surveyor indicated to her to the correct insulin pen was in the drawer, ULP-G returned to the cart saying "I get confused". ULP-G then removed the lispro, cleansed the port, primed the pen, and dialed to 10 units. ULP-G then went to R7's room and administered the insulin. ULP-G did not encourage or instruct R7 to go for a walk or to drink water, as instructed by the LPN. R7 went to the dining room which is in close proximately to his room and ate his meal. R7 consumed approximately 10-12 oz of water and flavored water and returned to his room. ULP-G did not encourage additional fluids during	01760			

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01760	Continued From page 12 the meal. R7's Progress Notes dated January 6, 2026, at 12:29 p.m., indicated "HHA reported that resident BS read Hi with the reader and HHA recheck with finger poke and BS 503. Writer instruct HHA to give resident water and encourage resident walk as much of us he can. Writer assessed resident and resident was sitting on the dining floor waiting for lunch. No s/s of hyperglycemia noted." A message had been sent to the provider. R7's orders dated January 7, 2026, included recheck of blood sugar after lunch and report to the provider. On January 6, 2026, at 2:20 p.m. clinical nurse supervisor (CNS)-B stated recheck of blood sugar was 375. On January 6, 2026, at 2:34 p.m., clinical nurse supervisor (CNS)-B stated ULP-G had been trained to check the MAR and complete the six rights of medication administration (right person, right medication, right dose, right route, right time, and right documentation), including checking the MAR to the insulin pen to ensure it was the correct medication and should have been doing that as she was trained. CNS-B further stated it is concerning that the wrong insulin would have been administered without intervention from the surveyor. In addition, CNS-B stated ULP-G should have followed LPN-H's directions and encouraged R7 to take a walk and drink water. R2 R2 was admitted to the facility on October 3, 2022, with diagnoses including diabetes, dementia, morbid obesity, congestive heart	01760			

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01760	Continued From page 13 failure, anxiety and depression. On January 6, 2026, at 7:56 a.m., the surveyor observed ULP-F administering Humalog insulin to R2. ULP-F did not check R2's blood glucose prior to administration of the insulin. On January 6, 2026, immediately following the medication administration, ULP-F stated he checked R2's blood sugar earlier but had to wait until right before R2 ate breakfast to administer the insulin. ULP-F showed the MAR documentation to the surveyor, which indicated the blood sugar was 105 at 6:58 a.m. R2's January 2026, MAR included the following: - Blood sugar checks at 7:45 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. Staff were to notify the nurse if blood glucose was less than 100 or greater than 350 and indicated "PLEASE NOTE, BLOOD SUGAR SHOULD BE CHECKED RIGHT BEFORE INSULIN IS GIVEN". - Humalog Kwikpen (insulin) inject 10 units three times a day before meals at 7:45 a.m., 11:45 a.m., and 4:45 p.m., hold for blood sugar less than 100. "PLEASE NOTE: SHORT-ACTING INSULIN IS MEANT TO COVER MEAL AND SHOULD BE ADMINISTERED APPROXIMATELY 15 MINUTES BEFORE RESIDENT EATS (NOT EARLIER)." - On January 2, 2026, at 7:45 a.m., R2's blood sugar was 98. Although R2's blood sugar was less than 100, Humalog was documented as administered. - On January 3, 2026, at 4:45 p.m., R2's blood sugar was documented as "0" and Humalog was documented as administered. R2's physician orders dated September 15, 2026,	01760			

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01760	Continued From page 14 included: - Blood sugar checks at 7:45 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. - Humalog Kwikpen (insulin) inject three times a day before meals at 7:45 a.m., 11:45 a.m., and 4:45 p.m., hold for blood sugar less than 100. "PLEASE NOTE: SHORT-ACTING INSULIN IS MEANT TO COVER MEAL AND SHOULD BE ADMINISTERED APPROXIMATELY 15 MINUTES BEFORE RESIDENT EATS (NOT EARLIER)." R2's progress notes for January 2026, included one notification to the nurse for a blood sugar of 71 on January 3, 2026, and insulin was held. There was no documentation of the January 2, 2026, blood glucose reading of 98, nor was there documentation of the January 3, 2026, documentation of the blood sugar being "0." R5 R5 was admitted on December 24, 2024, with diagnosis including diabetes. On January 6, 2026, at 8:05 a.m., ULP-F was preparing Humalog and Toujeo insulin for administration and stated he had checked R5's blood glucose at 7:21 a.m. while showing the surveyor the documentation. R5's January 2026, MAR included: - Blood sugar checks at 7:45 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. Staff were to notify the nurse if blood glucose was less than 100 or greater than 350 and indicated "PLEASE NOTE, BLOOD SUGAR SHOULD BE CHECKED RIGHT BEFORE INSULIN ADMINISTRATION". - Humalog Kwikpen (insulin) inject 8 units three times a day before meals at 7:45 a.m., 11:45 a.m., and 4:45 p.m., hold for blood sugar less	01760			

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01760	Continued From page 15 than 100. "PLEASE NOTE: SHORT-ACTING INSULIN IS MEANT TO COVER MEAL AND SHOULD BE ADMINISTERED APPROXIMATELY 15 MINUTES BEFORE RESIDENT EATS (NOT EARLIER)." - On January 4, 2026, at 4:45 p.m., R5's blood glucose was 85; although R5's blood sugar was less than 100, the Humalog insulin was administered. - On January 5, 2026, at 7:45 a.m., R5's blood glucose was 97; although R5's blood sugar was less than 100, the Humalog insulin was administered. R5's physician orders dated November 17, 2025, included Humalog insulin 8 units subcutaneously before meals. Hold if blood sugar is less than 100. R5's progress noted for January 2026, did not include documentation of R5's low blood sugars the evening of January 4, 2026, or the morning of January 5, 2026. On January 7, 2025, at 10:11 a.m., CNS-B stated staff should check blood sugars right before insulin administration and staff should have notified the nurse for low blood sugars and should have held the insulin when blood sugars were less than 100, per physician orders. R4 R4 was admitted on July 13, 2023, with diagnoses including a history of stroke, heart failure and cognitive impairment. On January 6, 2026, at 7:44 a.m., the surveyor observed ULP-F administering medications to R4, including fluticasone nasal spray. ULP-F	01760			

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01760	Continued From page 16 inserted the nasal spray tip of the nozzle into R4's left nostril and instilled three sprays, ULP-F then inserted the tip of the nozzle into the right nostril and instilled two sprays. R4's January 2026, MAR included fluticasone 50 mcg spray instill one spray in each nostril daily. R4's physician orders dated July 8, 2025, included fluticasone 50 mcg spray instill one spray in each nostril daily. On January 7, 2026, at 10:11 a.m., CNS-B stated medications should have been administered as ordered. The licensee's Insulin Pen Procedure dated February 2021, indicated the staff was to remove the correct insulin pen and check it to the MAR three times and perform the six rights. The licensee's Medications and Treatments Policy dated December 2025, section Medication Management Services Provided by Unlicensed Personnel indicated "The ULP will follow the six rights of medication administration". Lantus prescribing information dated June 2022, indicated the following: - Lantus is a long-acting insulin indicated to improve blood sugars; - Use LANTUS exactly as your healthcare provider tells you to. Your healthcare provider should tell you how much LANTUS to use and when to use it. - Know the amount of LANTUS you use. Do not change the amount of LANTUS you use unless your healthcare provider tells you to. - Check your insulin label each time you give your injection to make sure you are using the correct	01760			

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01760	Continued From page 17 insulin. - You may take LANTUS at any time during the day but you must take it at the same time every day. - Check your blood sugar levels. Ask your healthcare provider what your blood sugar should be and when you should check your blood sugar levels. - Do not make any changes to your dose or type of insulin without talking to your healthcare provider. Any change of insulin should be made cautiously and only under medical supervision. - LANTUS may cause serious side effects that can lead to death, including: - low blood sugar (hypoglycemia). Signs and symptoms that may indicate low blood sugar include: dizziness or light-headedness, sweating, confusion, headache, blurred vision, slurred speech, shakiness, fast heartbeat, anxiety, irritability or mood change, hunger. - severe allergic reaction (whole body reaction). Get medical help right away if you have any of these signs or symptoms of a severe allergic reaction: - a rash over your whole body, trouble breathing, a fast heartbeat, or sweating. - low potassium in your blood (hypokalemia). - heart failure. - Get emergency medical help if you have: trouble breathing; shortness of breath; fast heartbeat; swelling of your face, tongue, or throat; sweating; extreme drowsiness; dizziness; confusion. Humalog's prescribing information dated March 2013, included: - Accidental mix-ups between HUMALOG and other insulin's have been reported. To avoid medication errors between HUMALOG and other insulins, patients should be instructed to always check the insulin label before each injection.	01760			

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01760	Continued From page 18 - You must test your blood sugar levels while using an insulin such as HUMALOG. Your healthcare provider will tell you how often you should test your blood sugar level, and what to do if it is high or low. - HUMALOG (insulin lispro injection, USP [rDNA origin]) is an injectable rapid-acting man-made insulin. HUMALOG is used to treat people with diabetes for the control of high blood sugar. - Do not take HUMALOG if: · your blood sugar is too low (hypoglycemia). After treating your low blood sugar, follow your healthcare provider ' s instructions on the use of HUMALOG. - HUMALOG is a rapid-acting insulin. You should take HUMALOG within fifteen minutes before eating or right after eating a meal. - If you take too much HUMALOG, your blood sugar may fall low (hypoglycemia). You can treat mild low blood sugar by drinking or eating something sugary right away (fruit juice, sugar candies, or glucose tablets). It is important to treat low blood sugar right away because it could get worse and you could pass out (become unconscious). If you pass out, you will need help from another person or emergency medical services right away, and will need treatment with Glucagon injection or treatment at a hospital. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01760			
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880			

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01880	Continued From page 19 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 refrigerated medications were stored at the appropriate temperature in one of two medication refrigerators (assisted living refrigerator). 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 January 5, 2026, at 3:45 p.m., unlicensed personnel (ULP)-M opened the medication refrigerator in the assisted living. The surveyor and ULP-M observed the temperature to be 33 degrees Fahrenheit (F). ULP-M stated it is "kind of low" and would need to be adjusted. The surveyor observed the following medications in the refrigerator: R2 had five Humalog insulin pens and two Lantus insulin pens; R5 had three Toujeo insulin pens; R10 had three Trulicity (injectable diabetes medication); R11 had 33 capsules of acidophilus; R12 had 32 capsules of acidophilus; and	01880			

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01880	Continued From page 20 R13 had 2 capsules of acidophilus. After reviewing medications in the refrigerator with the surveyor, ULP-M then closed and locked the refrigerator without adjusting the temperature. On January 7, 2025, at 3:45 p.m., ULP-N unlocked the assisted living refrigerator and observed the temperature to be 34 degrees F. ULP-N stated it needs to be adjusted and adjusted the temperature dial inside the refrigerator. The licensee's temperature logs for the assisted living refrigerator included the following: - December 1, 2025, temperature of 29 degrees F. No documentation they had adjusted it. - December 4, 2025, temperature of 29 degrees F. No documentation they had adjusted it. - December 5, 2025, temperature of 36 degrees F. "adjusted temperature" - December 8, 2025, temperature of 32 degrees F. "adjusted temperature" - December 10, 2025, temperature of 28 degrees F. "adjusted temperature" - December 15, 2025, temperature of 31.5 degrees F. No documentation they had adjusted it. On January 5, 2025, at 10:00 a.m., the documentation of temperature was 38 degrees F. The licenses's undated, Refrigerator Temperature Check task information indicated "Record AL [assisted living] medication refrigerator temperature. Goal is to maintain 'fridge temp. between 38 - 42 degrees. If 'fridge temp. is out of this range, please adjust the dial near the freezer. Bigger number = cooler temperature; smaller number = warmer temperature. Report concerns to nurse.	01880			

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01880	Continued From page 21 On January 7, 2026, at 10:11 a.m., clinical nurse supervisor (CNS)-B stated staff should have adjusted the refrigerator when the temperature was noted to be too low. The Licensee's Medications and Treatments policy dated December 2025, included under Storage was the following instruction: - Medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). Store medications in a cool, dry place (25°C/77°F) unless specified to be refrigerated. Lantus prescribing information dated June 2022, indicated the following: - Store unused LANTUS in a refrigerator between 36°F and 46°F (2°C and 8°C). Do not freeze. Discard LANTUS if it has been frozen. Humalog's prescribing information dated March 2013, included: - Unopened HUMALOG should be stored in a refrigerator (36° to 46°F [2° to 8°C]), but not in the freezer. Do not use HUMALOG if it has been frozen. Toujeo prescribing information dated February 2015, included: - TOUJEO SoloStar disposable prefilled pen should not be stored in the freezer and should not be allowed to freeze. Discard TOUJEO SoloStar disposable prefilled pen if it has been frozen. Unopened TOUJEO SoloStar disposable prefilled pen should be stored in a refrigerator, 36°F -46°F (2°C - 8°C). Discard after the expiration date. Trulicity prescribing information dated September 2018, included: - Store your Pen in the refrigerator between 36°F	01880			

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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
01880	Continued From page 22 to 46°F (2°C to 8°C). - Do not freeze your Pen. If the Pen has been frozen, throw the Pen away and use a new Pen. 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 in two of four medication carts (MC2, MC4) and failed to ensure the full prescription label was visible for three of three residents (R2, R5, R7) who received insulin. 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).	01890			

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01890	Continued From page 23 The findings include: Medications carts On January 5, 2026, at 3:37 p.m., a review of MC2 was completed by the surveyor with unlicensed personnel (ULP)-L and the following was observed: - R7 had an albuterol inhaler without an open date - R3 had an albuterol inhaler without an open date - R3 had a Breo Ellipta inhaler without an open date - R8 had a Breo Ellipta inhaler without an open date On January 5, 2026, at 3:45 p.m., a review of MC2 was completed by the surveyor with ULP-M and the following was observed: - R9 had an albuterol inhaler without an open date Insulin pen labels On January 6, 2026, at 7:56 a.m., the surveyor observed ULP-F administering insulin to R2. R2 had a Lantus insulin pen and a Humalog insulin pen. Both pens had a date open label covering the directions for use on the pharmacy label. On January 6, 2026, at 8:05 a.m., the surveyor observed ULP-F administering insulin to R5. R5 had a Toujeo insulin pen and Humalog insulin pen. Both pens had a date open label covering the directions for use on the pharmacy label. On January 6, 2026, at 11:56 a.m., the surveyor observed ULP-F administering insulin to R7. R7 had a Humalog insulin pen and two Lantus insulin pens. All three pens had a date open label	01890			

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01890	Continued From page 24 covering the directions for use on the pharmacy label. On January 7, 2026, at 10:11 a.m., clinical nurse supervisor (CNS)-B stated she was unaware the inhalers were time sensitive and should have been marked when they were opened. CNS-B stated she will contact the pharmacy and request they do not cover the pharmacy label with the date open stickers. The Licensee's Medications and Treatments policy dated December 2025, included under Storage was the following: - Medication 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 date. - inhalers - Albuterol: 3 months, Breo Elipta was not listed Breo Elipta prescribing information dated 2017, indicated "Safely throw away BREO ELLIPTA in the trash 6 weeks after you open the foil tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler." Albuterol inhaler prescribing information dated March 2008, included "should be discarded when the counter reads 000 (after 200 sprays have been used) or 6 months after removal from the moisture-protective foil pouch, whichever comes first." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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01960	Continued From page 25	01960			
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments were administered as ordered for all three residents (R7, R2, R5) reviewed with blood glucose monitoring. 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: R7 R7 was admitted on October 24, 2024, with diagnoses including type 1 diabetes, congestive	01960			

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01960	Continued From page 26 heart failure, mild cognitive impairment, chronic kidney disease, and depression. R7 resided in the secured memory care unit of the facility. On January 6, 2026, at 11:42 a.m., unlicensed personnel (ULP)-G checked R7's blood glucose using his Freestyle Libre continuous monitor and the reading was "HI". ULP-G then retrieved the fingerstick blood glucose monitor and checked R7's blood glucose with a result of 503. ULP-G notified licensed practical nurse (LPN)-H. LPN-H instructed ULP-G to administer insulin as ordered and encourage R7 to walk and drink water. R7's Medication Administration Record (MAR) included the following: - Monitor Blood Sugar - obtain blood sugar reading. Report to nurse if blood sugar is lower than 80 or greater than 450. If the Freestyle sensor reads "high", repeat blood sugar by fingerstick method. - Insulin lispro injection (Humalog Kwikpen) - inject 10 units subcutaneously three times daily before meals. Hold only for blood sugar less than 60. Please note: short acting insulin is meant to cover meals and should be administered approximately 15 minutes before resident eats. hold short acting insulin only if blood sugar is less than 60 and resident is symptomatic. If short acting needs to be held prior to a meal, contact the nurse. May also administer short acting directly after the meal and recheck his blood sugar 30-60 minutes after insulin administration. R7's physician orders dated December 29, 2025, indicated lispro insulin administer 10 units prior to breakfast, lunch, and dinner. Do not hold short acting insulin unless blood sugar less than 60 and symptomatic. If short acting needs to be held prior to a meal, contact provider. May also	01960			

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01960	Continued From page 27 administer short acting directly after the meal and recheck his blood sugar 30-60 minutes after administration of insulin, R7's physician orders dated October 26, 2025, included: - Freestyle Libre use to check blood sugar five times a day - Accu-check use if Freestyle Libre is not working to check blood sugar five times a day On January 6, 2026, at 11:56 a.m., ULP-G administered insulin. ULP-G did not encourage or instruct R7 to go for a walk or to drink water, as instructed by the LPN. R7 went to the dining room which is in close proximity to his room and ate his meal. R7 consumed approximately 10-12 oz of water and flavored water and returned to his room. ULP-G did not encourage additional fluids during the meal. R7's Progress Notes dated January 6, 2026, at 12:29 p.m., indicated "HHA reported that resident BS read Hi with the reader and HHA recheck with finger poke and BS 503. Writer instruct HHA to give resident water and encourage resident walk as much of us he can. Writer assessed resident and resident was sitting on the dining floor waiting for lunch. no s/s of hyperglycemia noted." A message had been sent to the provider. R7's orders dated January 7, 2026, included recheck of blood sugar after lunch and report to the provider. On January 6, 2026, at 2:20 p.m. clinical nurse supervisor (CNS)-B stated recheck of blood sugar was 375.	01960			

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01960	Continued From page 28 On January 6, 2026, at 2:34 p.m. clinical nurse supervisor (CNS)-B stated ULP-G should have followed LPN-H's directions and encouraged R7 to take a walk and drink water. R2 R2 was admitted to the facility on October 3, 2022, with diagnoses including diabetes, dementia, morbid obesity, congestive heart failure, anxiety and depression. On January 6, 2026, at 7:56 a.m., the surveyor observed ULP-F administering Humalog insulin to R2. ULP-F did not check R2's blood glucose prior to administration of the insulin. On January 6, 2026, immediately following the medication administration, ULP-F stated he checked R2's blood sugar earlier but had to wait until right before R2 ate breakfast to administer the insulin. ULP-F showed the MAR documentation to the surveyor, which indicated the blood sugar was 105 at 6:58 a.m. (one hour prior to insulin administration). R2's January 2026, MAR included the following: - Blood sugar checks at 7:45 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. Staff were to notify the nurse if blood glucose was less than 100 or greater than 350 and indicated "PLEASE NOTE, BLOOD SUGAR SHOULD BE CHECKED RIGHT BEFORE INSULIN IS GIVEN". - Humalog Kwikpen (insulin) inject 10 units three times a day before meals at 7:45 a.m., 11:45 a.m., and 4:45 p.m., hold for blood sugar less than 100. "PLEASE NOTE: SHORT-ACTING INSULIN IS MEANT TO COVER MEAL AND SHOULD BE ADMINISTERED APPROXIMATELY 15 MINUTES BEFORE RESIDENT EATS (NOT EARLIER)."	01960			

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01960	Continued From page 29 - On January 2, 2026, at 7:45 a.m., blood sugar was 98. Although blood sugar was less than 100, Humalog was documented as administered. - On January 3, 2026, at 4:45 p.m., blood sugar was documented as "0" and Humalog was documented as administered. R2's physician orders dated September 15, 2026, included: - Blood sugar checks at 7:45 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. - Humalog Kwikpen (insulin) inject three times a day before meals at 7:45 a.m., 11:45 a.m., and 4:45 p.m., hold for blood sugar less than 100. "PLEASE NOTE: SHORT-ACTING INSULIN IS MEANT TO COVER MEAL AND SHOULD BE ADMINISTERED APPROXIMATELY 15 MINUTES BEFORE RESIDENT EATS (NOT EARLIER)." R2's progress notes for January 2026, included one notification to the nurse for a blood sugar of 71 on January 3, 2026, and insulin was held. There was no documentation of the January 2, 2026, blood glucose reading of 98, nor was there documentation of the January 3, 2026, documentation of the blood sugar being "0" R5 R5 was admitted on December 24, 2024, and diagnosis included diabetes. On January 6, 2026, at 8:05 a.m., ULP-F was preparing Humalog and Toujeo insulin for administration and stated he had checked R5's blood glucose at 7:21 a.m. while showing the surveyor the documentation. R5's January 2026, MAR included:	01960			

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01960	Continued From page 30 - Blood sugar checks at 7:45 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. Staff were to notify the nurse if blood glucose was less than 100 or greater than 350 and indicated "PLEASE NOTE, BLOOD SUGAR SHOULD BE CHECKED RIGHT BEFORE INSULIN ADMINISTRATION". - Humalog Kwikpen (insulin) inject 8 units three times a day before meals at 7:45 a.m., 11:45 a.m., and 4:45 p.m., hold for blood sugar less than 100. "PLEASE NOTE: SHORT-ACTING INSULIN IS MEANT TO COVER MEAL AND SHOULD BE ADMINISTERED APPROXIMATELY 15 MINUTES BEFORE RESIDENT EATS (NOT EARLIER)." - On January 4, 2026, at 4:45 p.m. R5's blood glucose was 85; although R5's blood sugar was less than 100, the Humalog insulin was administered. -On January 5, 2026, at 7:45 a.m. R5's blood glucose was 97; although R5's blood sugar was less than 100, the Humalog insulin was administered. R5's physician orders dated November 17, 2025, included Humalog insulin 8 units subcutaneously before meals. Hold if blood sugar is less than 100. R5's progress noted for January 2026, did not include documentation of R5's low blood sugars the evening of January 4, 2026, or the morning of January 5, 2026. On January 7, 2026, at 10:11 a.m. CNS-B stated staff should check blood sugars right before insulin administration and staff should have notified the nurse for low blood sugars and should have held the insulin when blood sugars were less than 100, per physician orders.	01960			

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01960	Continued From page 31 The licensee's Medications and Treatments Policy dated December 2025, section Medication Management Services Provided by Unlicensed Personnel indicated "The ULP will follow the six rights of medication administration". Lantus prescribing information dated June 2022, indicated the following: - Lantus is a long-acting insulin indicated to improve blood sugars; - Use LANTUS exactly as your healthcare provider tells you to. Your healthcare provider should tell you how much LANTUS to use and when to use it. - Know the amount of LANTUS you use. Do not change the amount of LANTUS you use unless your healthcare provider tells you to. - Check your insulin label each time you give your injection to make sure you are using the correct insulin. - You may take LANTUS at any time during the day but you must take it at the same time every day. - Check your blood sugar levels. Ask your healthcare provider what your blood sugar should be and when you should check your blood sugar levels. - Do not make any changes to your dose or type of insulin without talking to your healthcare provider. Any change of insulin should be made cautiously and only under medical supervision. - LANTUS may cause serious side effects that can lead to death, including: - low blood sugar (hypoglycemia). Signs and symptoms that may indicate low blood sugar include: dizziness or light-headedness, sweating, confusion, headache, blurred vision, slurred speech, shakiness, fast heartbeat, anxiety, irritability or mood change, hunger.	01960			

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01960	Continued From page 32 - severe allergic reaction (whole body reaction). Get medical help right away if you have any of these signs or symptoms of a severe allergic reaction: - a rash over your whole body, trouble breathing, a fast heartbeat, or sweating. - low potassium in your blood (hypokalemia). - heart failure. - Get emergency medical help if you have: trouble breathing; shortness of breath; fast heartbeat; swelling of your face, tongue, or throat; sweating; extreme drowsiness; dizziness; confusion. Humalog's prescribing information dated March 2013, included: - Accidental mix-ups between HUMALOG and other insulin's have been reported. To avoid medication errors between HUMALOG and other insulins, patients should be instructed to always check the insulin label before each injection. - You must test your blood sugar levels while using an insulin such as HUMALOG. Your healthcare provider will tell you how often you should test your blood sugar level, and what to do if it is high or low. - HUMALOG (insulin lispro injection, USP [rDNA origin]) is an injectable rapid-acting man-made insulin. HUMALOG is used to treat people with diabetes for the control of high blood sugar. - Do not take HUMALOG if: · your blood sugar is too low (hypoglycemia). After treating your low blood sugar, follow your healthcare provider ' s instructions on the use of HUMALOG. - HUMALOG is a rapid-acting insulin. You should take HUMALOG within fifteen minutes before eating or right after eating a meal. - If you take too much HUMALOG, your blood sugar may fall low (hypoglycemia). You can treat mild low blood sugar by drinking or	01960			

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01960	Continued From page 33 eating something sugary right away (fruit juice, sugar candies, or glucose tablets). It is important to treat low blood sugar right away because it could get worse and you could pass out (become unconscious). If you pass out, you will need help from another person or emergency medical services right away, and will need treatment with Glucagon injection or treatment at a hospital. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure a resident (R7) received appropriate care and services related to diabetes care and medication administration. This resulted in an immediate correction order identified on January 6, 2025. In addition the facility failed to ensure staff probably stored medications for later use for one of one resident (R4).	02320			

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02320	Continued From page 34 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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: R7 was admitted on October 24, 2024, with diagnoses including type 1 diabetes, congestive heart failure, mild cognitive impairment, chronic kidney disease, and depression. R7 resided in the memory care unit of the facility. On January 6, 2026, at 11:42 a.m., the surveyor observed unlicensed personnel (ULP)-G check R7's blood glucose using his Freestyle Libre continuous monitor and the reading was "HI". ULP-G then retrieved the fingerstick blood glucose monitor and checked R7's blood glucose with a result of 503. ULP-G notified licensed practical nurse (LPN)-H. LPN-H instructed ULP-G to administer insulin as ordered and encourage R7 to walk and drink water. R7's Medication Administration Record (MAR) included the following: - Monitor Blood Sugar - obtain blood sugar reading. Report to nurse if blood sugar is lower than 80 or greater than 450. If the Freestyle sensor reads "high", repeat blood sugar by fingerstick method. - Insulin lispro injection (Humalog Kwikpen) - inject 10 units subcutaneously three times daily before meals. Hold only for blood sugar less than 60. Please note: short acting insulin is meant to cover meals and should be administered	02320			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 35 approximately 15 minutes before resident eats. hold short acting insulin only if blood sugar is less than 60 and resident is symptomatic. If short acting needs to be held prior to a meal, contact the nurse. May also administer short acting directly after the meal and recheck his blood sugar 30-60 minutes after insulin administration. - Lantus Solostar injection - inject 10 units subcutaneously at bedtime. R7's physician orders dated December 29, 2025, indicated lispro insulin administer 10 units prior to breakfast, lunch, and dinner. Do not hold short acting insulin unless blood sugar less than 60 and symptomatic. If short acting needs to be held prior to a meal, contact provider. May also administer short acting directly after the meal and recheck his blood sugar 30-60 minutes after administration of insulin, R7's physician orders dated October 26, 2025, included: - Lantus Solostar injection - inject 10 units subcutaneously at bedtime. - Freestyle Libre use to check blood sugar five times a day - Accu-check, use if Freestyle Libre is not working, to check blood sugar five times a day On January 6, 2026, at 11:56 a.m., the surveyor observed ULP-G remove R7's Lantus insulin pen, cleaned port, primed the pen, and dialed the dose to 10 units. ULP-G then locked the cart, closed the screen and began walking to R7's room. When ULP-G reached R7's door, the surveyor intervened and informed ULP-G she had the wrong insulin. ULP-G returned to the cart, removed the other Lantus insulin pen (which was empty) and then put it back in the cart. (The lispro insulin was sitting next to the Lantus.) ULP-G	02320			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 36 went to the refrigerator to get another insulin pen and stated the pen was empty (referring to the empty Lantus pen) and the surveyor indicated to her the other pen was in the drawer. ULP-G returned to the cart saying "I get confused". ULP-G then removed the lispro, cleaned the port, primed the pen, and dialed to 10 units. ULP-G then went to R7's room and administered the insulin. ULP-G did not encourage or instruct R7 to go for a walk or to drink water, as instructed by the LPN. R7 went to the dining room, which is in close proximately to his room, and ate his meal. R7 consumed approximately 10-12 oz of water and flavored water, and returned to his room. ULP-G did not encourage additional fluids during the meal. R7's Progress Notes dated January 6, 2026, at 12:29 p.m., indicated "HHA (home health aide) reported that resident BS (blood sugar) read Hi with the reader and HHA recheck with finger poke and BS 503. Writer instruct HHA to give resident water and encourage resident walk as much as he can. Writer assessed resident and resident was sitting on the dining floor waiting for lunch. No s/s (signs/symptoms) of hyperglycemia noted." A message had been sent to the provider. R7's orders dated January 6, 2026, included recheck of blood sugar after lunch and report to the provider. On January 6, 2026, at 2:20 p.m., clinical nurse supervisor (CNS)-B stated recheck of blood sugar was 375. On January 6, 2026, at 2:34 p.m., CNS-B stated ULP-G had been trained to check the MAR and	02320			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
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02320	Continued From page 37 complete the six rights of medication administration (right person, right medication, right dose, right route, right time, and right documentation), including checking the MAR to the insulin pen to ensure it was the correct medication, and should have been doing that as she was trained. CNS-B further stated it is concerning that the wrong insulin would have been administered without intervention from the surveyor. In addition, CNS-B stated ULP-G should have followed LPN-H's directions and encouraged R7 to take a walk and drink water. The licensee's Insulin Pen Procedure dated February 2021, indicated the staff was to remove the correct insulin pen and check it to the MAR three times and perform the six rights. The licensee's Medications and Treatments Policy dated December 2025, section Medication Management Services Provided by Unlicensed Personnel indicated "the ULP will follow the 6 rights of medication administration". Lantus prescribing information dated June 2022, indicated the following: - Lantus is a long-acting insulin indicated to improve blood sugars; - Use LANTUS exactly as your healthcare provider tells you to. Your healthcare provider should tell you how much LANTUS to use and when to use it. - Know the amount of LANTUS you use. Do not change the amount of LANTUS you use unless your healthcare provider tells you to. - Check your insulin label each time you give your injection to make sure you are using the correct insulin. - You may take LANTUS at any time during the day but you must take it at the same time every	02320			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L			STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 38 day. - Check your blood sugar levels. Ask your healthcare provider what your blood sugar should be and when you should check your blood sugar levels. - Do not make any changes to your dose or type of insulin without talking to your healthcare provider. Any change of insulin should be made cautiously and only under medical supervision. - LANTUS may cause serious side effects that can lead to death, including: - low blood sugar (hypoglycemia). Signs and symptoms that may indicate low blood sugar include: dizziness or light-headedness, sweating, confusion, headache, blurred vision, slurred speech, shakiness, fast heartbeat, anxiety, irritability or mood change, hunger. - severe allergic reaction (whole body reaction). Get medical help right away if you have any of these signs or symptoms of a severe allergic reaction: - a rash over your whole body, trouble breathing, a fast heartbeat, or sweating. - low potassium in your blood (hypokalemia). - heart failure. - Get emergency medical help if you have: trouble breathing; shortness of breath; fast heartbeat; swelling of your face, tongue, or throat; sweating; extreme drowsiness; dizziness; confusion. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level will remain at G. In addition, the licensee failed to properly store	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER NORBELLA SENIOR LIVING PRIOR L		STREET ADDRESS, CITY, STATE, ZIP CODE 4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 39 medication for later use. On January 6, 2026, at 7:44 a.m., the surveyor observed ULP-F administering medication to R4. Upon the start of observation, ULP-F had set up R4's oral medications. ULP-F put R4's medications into R4's hand and R4 took all but one pill. R4 put the remaining pill back into the medication cup, stating she wanted to take it with breakfast. ULP-F took the pill cup back to the medication cart and placed it into the top drawer and stated he would bring it to her when she was eating breakfast. The medication was not labeled with any identifying information. On January 7, 2026, at 10:11 a.m., CNS-B stated staff were trained to place the pill in an envelope with all the required information as they would for an unplanned time away and staff should have followed that process. The licensee's Medication & Treatment policy dated December 2025, indicated the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. No further information was provided.	02320			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

NORBELLA SENIOR LIVING PRIOR L
4285 FOUNTAIN HILL DRIVE NE
Prior Lake, MN 55372
Scott County
Parcel:

Phone:

License Info

License: HFID 37315

Risk:
License:
Expires on:
CFPM: James M. Area
CFPM #: FM115753; Exp: 03/07/2026

Inspection Info

Report Number: F1047261006
Inspection Type: Full - Single
Date: 1/6/2026 Time: 10:00 am
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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator S. Haag.

The establishment has a commercial kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 F1047261006 from 1/6/2026

Gina Walker
Culinary Director

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

NORBELLA SENIOR LIVING PRIOR L
Prior Lake
County/Group: Scott County

Inspection Info

Report Number: F1047261006
Inspection Type: Full
Date: 1/6/2026
Time: 10:00 am

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

Location: Walk-in Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

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

Location: Prep Cooler at 38 Degrees F.

Comment:

Violation Issued?: No

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

Location: Norlake Upright Cooler at 39 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

Page: 1

Establishment Info

NORBELLA SENIOR LIVING PRIOR L
Prior Lake
County/Group: Scott County

Inspection Info

Report Number: F1047261006
Inspection Type: Full
Date: 1/6/2026
Time: 10:00 am

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 168 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** 3-Compartment Sink

Location: Dishwashing Area **Equal To** 400 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37315016	Date: 1/6/2026
Facility Name: Norbella Senior Living Prior Lake	
Facility Address: 4285 Fountain Hill Dr. NE, Prior Lake, MN 55372	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments:

An extension cord was in use to power a tv and other devices in resident room 106.

An extension cord was used to power several devices in resident room 103.

Several extension cords were connected to each other in sequence and used to power a phone charger in resident room 117.

3. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments: The rated fire door to the breakroom in the facility was propped open with a piece of metal which prevented the door from closing and latching properly.

4. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the

capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: The memory care unit was equipped with controlled egress doors that were not readily openable from the egress side. There was no supplied remote release device that would unlock the doors that was observed during the tour. Facility staff confirmed that no such device was present at the facility to unlock the doors, but that there are plans in the works to have such switch installed.