



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 17, 2026

Licensee
Azalea Homes LLC
5857 Perry Avenue North
Crystal, MN 55429

RE: Project Number SL39267016

Dear Licensee:

On April 6, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on November 20, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

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

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 4, 2026

Licensee
Azalea Homes LLC
5857 Perry Avenue North
Crystal, MN 55429

RE: Project Number(s) SL39267016

Dear Licensee:

On February 17, 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 November 20, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 20, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 20, 2025, found not corrected at the time of the February 17, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - \$1,000.00

The details of the violations noted at the time of this follow-up survey completed on February 17, 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 \$1,000.00**. 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 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 Casey DeVries at 651-201-5917.

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,



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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/17/2026
NAME OF PROVIDER OR SUPPLIER AZALEA HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5857 PERRY AVENUE NORTH CRYSTAL, MN 55429		
(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 SL39267016-1 On February 17, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 20, 2025. At the time of the survey, there were three residents all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued: 0470	{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.		
{0 330} SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	{0 330}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 330}	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by:	{0 330}	Not reviewed during this survey.		
{0 470} SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 2 facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing at all times to meet the reasonably foreseeable unscheduled needs of each resident as required by the resident's assessment and/or service plan. In addition, the licensee failed to ensure the daily staff schedule posted was intelligible for residents, staff, and visitors to review. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 17, 2025, upon initiation of the survey, the licensee had a census of three residents. The licensee's staff list dated February 17, 2026, indicated nine staff members were employed with the licensee and included the following staff members: -two owners: one of which was the housing manager (HM) and the other was the licensed	{0 470}			

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{0 470}	Continued From page 3 assisted living director (LALD); -two registered nurses; -one temporary administration; and -four unlicensed personnel (ULP). R2 admitted to the license on April 3, 2024, and began receiving assisted living services. R2's diagnoses included spastic quadriplegic (paralysis of all four limbs) cerebral palsy, cellulitis of bilateral lower extremities, major depressive disorder, neuromuscular dysfunction of the bladder, chronic pain, post-traumatic stress disorder, and diabetes. R2's service plan titled Addendum A to Resident's Assisted Living Contract (Waiver) signed January 8, 2026, indicated R2 received assistance with activities, bathing, bedmaking, catheter care, dressing, finances, grooming, housekeeping, toileting, laundry, behavior management, meals, medication administration, repositioning, blood glucose monitoring, shopping, socialization, transfers, transportation, and wound care. R2's Master Care Plan dated January 6, 2026, indicated the following: -R2 was unable to walk; -R2 needed assistance with turning and repositioning; -R2 required a mechanical lift for transfers; and -R2 assist two with the Hoyer lift. The licensee's Corrective Action Plan - Tag 0470 effective November 21, 2025, indicated the licensee had two awake direct care staff members on each shift from 7:00 a.m. to 7:00 p.m. and 7:00 p.m. to 7:00 a.m. The licensee's staffing plan dated November 23,	{0 470}			

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{0 470}	Continued From page 4 2025, included the following: - at least one resident required a two-person assist for transfers, which directly impacted minimum staffing requirements on all shifts; - when a resident required a two-person transfer, a minimum of two trained ULP must be physically present on the shift; - day and overnight shift required a minimum of two ULP due to resident transfers and safety needs; and - due to resident acuity and the presence of a two-person transfer requirement, staffing levels may not drop below two ULP on any shift. On February 17, 2026, at 9:30 a.m. upon entering the facility, the surveyor observed ULP-B. The surveyor inquired if there were other staff members present in the facility. ULP-B stated there was no other staff member with them and owner/licensed assisted (O/LALD)-D left the facility five minutes ago. On February 17, 2026, at 9:39 a.m., the surveyor called owner (O)-A to alert them of the survey being conducted. On February 17, 2026, at 9:42 a.m., the surveyor observed the licensee's common area and observed the licensee's staff schedule posting titled Direct Support Personnel Block Schedule located at the main entryway. The schedule indicated Monday through Sunday there were two staff members that worked from 7:00 a.m. to 7:00 p.m., and two staff members that worked from 7:00 p.m. to 7:00 a.m. The staff posting did not contain dates; however, it listed four different weeks. The surveyor was unable to discern what week in the schedule the licensee was on. Although the staff schedule was posted, a person trying to interpret the schedule would be reliant on	{0 470}			

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{0 470}	Continued From page 5 knowing what week it was on in order to understand the schedule. On February 17, 2026, at 9:50 a.m., ULP-B stated there were always two people at the facility when they worked; however, today O/LALD-D had to leave to get something. The surveyor inquired if it was the first time they were left without a second person in the facility. ULP-B stated O/LALD-D normally worked in the yard when they worked with them because if R2 needed to use the bed pan or reposition then there would be a second person to assist with R2's needs. On February 17, 2026, at 9:52 a.m., the surveyor attempted to interview R2. R2 declined the interview. On February 17, 2026, at 9:58 a.m., R3 stated there was usually one or two staff members present at the facility. The surveyor inquired if there were always two staff members present at the facility. R3 stated, "sometimes there is just one person." On February 17, 2026, at 10:01 a.m., 31 minutes after the surveyor entered the facility, O-A entered the facility. On February 17, 2026, at 10:34 a.m., O-A stated they normally worked the day shift with ULP-B; however, another one of the homes they owned had a plumbing issue they had to deal with. O-A stated O/LALD-D left the facility because they were sick. O-A stated there were normally two people present at the facility on each shift. O-A stated the licensee recently hired two new ULP that were listed on the staff list; however, they were waiting on fingerprints to complete the	{0 470}			

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{0 470}	Continued From page 6 background studies. O-A stated the posted staff schedule was for four weeks. The surveyor inquired how a resident would know what date they were on. O-A stated they would know by the day of the week listed and week one meant it was the first week of the month, week two meant second week of the month, week three meant third week of the month, and week four meant fourth week of the month. O-A stated the licensee was going to switch to a different scheduling program soon, and it would contain the date of the schedule on it. The licensee's Two - Person Assist / Transfer Staffing Requirement policy dated November 21, 2025, indicated the licensee ensured that a minimum of two ULP were scheduled and physically present each shift at all times when any resident required a two person assist or two-person transfer. No further information was provided.	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and	{0 480}			

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

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{0 480}	Continued From page 8	{0 480}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 510} SS=D	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:	{0 510}			
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	{0 630}			

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{0 630}	Continued From page 9 self-abuse. This MN Requirement is not met as evidenced by:	{0 630}	Not reviewed during this survey.		
{0 650} SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}			

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{0 680}	Continued From page 10 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	{0 780}	Not reviewed during this survey.		

Minnesota Department of Health
STATE FORM 6899 SMNE12 If continuation sheet 12 of 22

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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
{0 810}	Continued From page 12 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}			
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical	{0 940}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 940}	Continued From page 13 assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	{0 940}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	{0 970}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 970}	Continued From page 14 include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	{01060}			

Minnesota Department of Health

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{01060}	Continued From page 15 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}	Not reviewed during this survey.		
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	{01640}			

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{01640}	Continued From page 16 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	{01650}			

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{01650}	Continued From page 17 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}	Not reviewed during this survey.		
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional	{01730}			

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{01730}	Continued From page 18 when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}	Not reviewed during this survey.		
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	{01770}			
{01890} SS=D	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	{01890}			

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{01890}	Continued From page 19 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}	Not reviewed during this survey.		
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}			
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen	{01940}			

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{01940}	Continued From page 20 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services	{02310}			

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{02310}	Continued From page 21 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 24, 2025

Licensee
Azalea Homes LLC
5857 Perry Avenue North
Crystal, MN 55429

RE: Project Number(s) SL39267016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

St - 0 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$500.00

St - 0 - 0420 - 144g.40 Subdivision 1 - Responsibility For Housing And Services - \$1,000.00

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$1,000.00

St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - \$1,000.00

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$5,000.00.** 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/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" and last name "DeVries" clearly distinguishable.

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

CLN

Minnesota Department of Health

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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: SL39267016-0 On November 17, 2025, through November 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the Assisted Living Facility license. An immediate correction order was identified on November 17, 2025, issued for SL39267016-0, tag identification 0495. An immediate correction order was identified on November 18, 2025, issued for SL39267016-0, tag identification 0470. An immediate correction order was identified on November 18, 2025, issued for SL39267016-0, tag identification 0775.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 330 SS=F	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. 144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide documentation pertaining to resident services in a timely manner. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER AZALEA HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5857 PERRY AVENUE NORTH CRYSTAL, MN 55429		
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0 330	Continued From page 2 On November 17, 2025, at 1:19 p.m., the surveyor requested R1 and R2's medication administration record (MAR) for the month of November and signed prescriber's orders for all medications listed on the MARs. On November 18, 2025, at approximately 9:15 a.m., the surveyor received a MAR for R1, R2, and R3. For R1, the surveyor received pages one through three out of five. For R2, the surveyor received pages one through four out of eight. For R3, the surveyor received pages one through four out of seven. The last pages of the MAR would contain a section for notes. On November 19, 2025, at 9:31a.m., O-A provided the surveyor with R1's prescriber orders and stated they believed they had provided them on November 18, 2025. On November 20, 2025, at 7:21 a.m., the surveyor requested the following documents, which were previously requested but had not yet been received. - R1's current prescriber order for Seroquel; - R1's page four and five of MAR; - R2's current provider order for nystatin, debrox ear drop, and oxycodone; - R2's page four through six of MAR; - R3's current order for calcium, metocarbamol, loperamide, olanzapine, and Ventolin inhaler; and - R3's page five through seven of MAR. The surveyor explained the last pages of the MAR were needed to review the notes section. On November 20, 2025, at 8:27 a.m., via email, O-A wrote, "I will get you the requested items as soon as I can. Would you like them emailed or faxed?"	0 330			

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0 330	Continued From page 3 On November 20, 2025, at 9:04 a.m., via email, the surveyor responded to O-A and requested the documents via email. On November 20, 2025, at 10:22 a.m., via telephone, the surveyor reminded O-A to send the documents that were requested at 7:21 a.m. On November 20, 2025, at 12:35 p.m., via email, the surveyor reminded the licensee to send the documents requested at 7:21 a.m. On November 20, 2025, at 12:59 p.m., via email, O-A wrote, "Working on them now." On November 20, 2025, at 1:55 p.m., via telephone, the surveyor reminded O-A to send documents previously requested at 7:21 a.m. On November 20, 2025, at 3:03 p.m., the surveyor received R1, R2, and R2's prescriber's orders that were requested, however, upon conclusion of the survey, the surveyor did not receive the last pages of the MAR for R1, R2, and R3. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 420 SS=I	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the	0 420			

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0 420	Continued From page 4 provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient housing and service-related management, control, and operation of the facility. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living licensure issued on January 5, 2025, with an expiration date of January 4, 2026. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page five and of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or	0 420			

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0 420	Continued From page 5 subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner (O)-A on November 19, 2024. As a result of this survey, the following orders were issued under tag identification numbers 0330, 0470, 0480, 0495, 0510, 0630, 0650, 0680, 0775, 0780, 0810, 0940, 0970, 1060, 1640, 1650, 1730, 1770, 1890, 1910, 1940, and 2310, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. Tags 0470, 0495, and 0775 were issued with an immediate time period for correction during the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470			

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0 470	Continued From page 6 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing at all times to meet the reasonably foreseeable unscheduled needs of each resident as required by the resident's assessment and/or service plan. In addition, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This practice resulted in a level three violation (a	0 470			

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0 470	Continued From page 7 violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 17, 2025, upon initiation of the survey, the licensee had a census of three residents. R1 R1 admitted to the licensee on July 18, 2023, and began receiving assisted living services. R1's diagnoses included Alzheimer's disease and osteoporosis with pathological fracture presence. R1's Service Plan signed June 21, 2023, indicated R1 needed assistance with homemaking, shopping, appointments, activities, meals, dressing, grooming, bathing, medication management, incontinence, positioning, transfers, and mobility. R1's ongoing assessment dated September 21, 2025, indicated the following: - R1 was non-ambulatory and cannot evacuate without help; and - R1 required continuous nursing care and observation during an evacuation. R3 R3 admitted to the licensee on July 31, 2025, and began receiving assisted living services. R3's diagnosis included leukemia.	0 470			

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0 470	Continued From page 8 R3's unsigned service plan indicated R3 received assistance with activities, ambulation, bathing, catheter care, dressing, finances, grooming, housekeeping, medication administration, meals, vital sign monitoring, shopping, toileting, transfers, and transportation. R3's ongoing assessment dated September 14, 2025, indicated the following: - R3 needs help in an emergency and is unable to evacuate without help; and - R3's is ambulatory and requires moderate nursing care and moderate assistance in an evacuation. R2 R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's diagnoses included spastic quadriplegic (paralysis of all four limbs) cerebral palsy, cellulitis of bilateral lower extremities, major depressive disorder, neuromuscular dysfunction of the bladder, chronic pain, post-traumatic stress disorder, and diabetes. R2's unsigned service plan indicated R2 received assistance with activities, bathing, catheter care, dressing, grooming, housekeeping, incontinence care, laundry, meals, medication administration, positioning, blood glucose monitoring, shopping, transfers, and wound care. R2's Master Care Plan dated October 30, 2025, indicated the following: - R2 was unable to walk; - R2 used a mechanical lift to transfer; - R2 needed assistance with bed mobility to be turned and repositioned;	0 470			

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0 470	Continued From page 9 - R2 had an electric wheelchair and needed standby assistance when it was use; - R2 had bed rails on their bed; and - R2 was not able to evacuate without help in an emergency and needed assist of two staff members with mechanical lift. R2's Assessment dated October 30, 2025, indicated the following: - R2 used a mechanical lift for transfers; - R2 had a power wheelchair and required standby assist when in use; - R2 had bed rails on bed; and - R2 was not able to evacuate without help in an emergency and needed assist of two staff members with mechanical lift. The licensee's Staffing Plan signed by owner (O)-A on June 20, 2025, indicated the following: - the licensee's staffing level met or exceeded the requirements of Minnesota state statue 144G.41 and were sufficient to meet the scheduled and unscheduled needs of all residents at all times 24 hours per day; - from 7:00 a.m. to 7:00 p.m., two direct care staff were on-site, and a registered nurse (RN) was on-call with availability to come onsite as needed; - from 7:00 p.m. to 7:00 a.m., there was one awake overnight staff member on-site, an on-call direct care provider, and an on-call RN. - the staffing plan was reviewed and revised on July 5, 2023, June 23, 2024, and June 20, 2025. The Staffing Plan was not created by the CNS. The licensee's Direct Support Personnel Block Schedule located at the main entryway indicated Monday through Sunday there were two staff members working from 7:00 a.m. to 7:00 p.m., and one staff member was working from 7:00 p.m. to 7:00 a.m. The sheet did not contain dates	0 470			

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0 470	Continued From page 10 however listed four weeks. On November 17, 2025, O-A provided the surveyor with an undated and untitled document and indicated it was a quick reference sheet to what cares were needed within the home. The document indicated R2 required assist of 2 for mechanical full body lifts. On November 17, 2025, between 9:20 a.m. and 10:12 a.m., during the entrance conference, O-A stated the staff members worked 12-hour shifts. The day shift was from 7:00 a.m. to 7:00 p.m., and there were two staff members on-site. The night shift was from 7:00 p.m. to 7:00 a.m., and there was one staff member on-site. O-A stated R2 used a mechanical full body lift however, they did not transfer out of bed in the overnight hours and required assist of one with bed mobility and other cares that occurred in the overnight. On November 18, 2025, at 7:10 a.m., owner/licensed assisted living director (O/LALD)-D stated they were able to come and assist at the facility during the weekdays if it was needed however, they worked full time during the night shift at the facility. O/LALD-D stated if there was an emergency and they needed to evacuate, they would call another staff member to come to the facility to assist because R2 required two people to transfer them. O/LALD-D stated O-A lived 20 minutes away from the facility and CNS-C lived 10 minutes away from the facility. O/LALD-D stated they had been working with one person in the overnight hours for a few months. O/LALD-D stated they had been discussing hiring another overnight worker however, they had not yet due to available funds. O/LALD-D inquired to the surveyor if they could hire an overnight worker who lived three minutes away and who could just	0 470			

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0 470	Continued From page 11 be on-call to assist in lowering cost levels in the overnight hours. On November 18, 2025, at 7:50 a.m., the surveyor observed a full body mechanical lift manufactured by Hi-Fortune and unlicensed personnel (ULP)-B stated the lift was used by R2. On November 18, 2025, at 10:39 a.m., CNS-C stated the licensee's managers created and managed the staffing plan. CNS-C stated they did review the staff schedules which showed them all staff were scheduled for 12 hours a time. CNS-C stated they did not have anything to do with any part with the staffing plan at this time. On November 18, 2025, at 10:40 a.m., O-A stated they created the staffing plan, and they reviewed the staffing plan quarterly. O-A stated they did not document the quarterly reviews. O-A stated they based the staffing level on the care needs of the residents. The licensee's 4.06 Staffing & Scheduling policy dated January 1, 2024, indicated the CNS would develop and implement a written staffing plan that provides an adequate number of qualified direct care staff to meet the resident's needs 24-hours a day, seven days a week. The CNS must ensure staffing levels were adequate to address the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470			

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0 480	Continued From page 12	0 480			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480			

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0 480	Continued From page 13 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 17, 2025, for the specific Minnesota Food Code violations. The	0 480			

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0 480	Continued From page 14 Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. 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: The licensee held an assisted living licensure valid through January 4, 2026. The licensee's current census was three residents. R1 R1 admitted to the licensee on July 18, 2023, and began receiving assisted living services.	0 495			

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NAME OF PROVIDER OR SUPPLIER AZALEA HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5857 PERRY AVENUE NORTH CRYSTAL, MN 55429			
(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
0 495	Continued From page 15 R1's diagnoses included Alzheimer's disease and osteoporosis with pathological fracture presence. R1's Service Plan signed June 21, 2023, indicated R1 needed assistance with homemaking, shopping, appointments, activities, meals, dressing, grooming, bathing, medication management, incontinence, positioning, transfers, and mobility. R2 R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's diagnosis included cerebral palsy. R2's unsigned service plan indicated R2 received assistance with activities, bathing, catheter care, dressing, grooming, housekeeping, incontinence care, laundry, meals, medication administration, positioning, blood glucose monitoring, shopping, transfers, and wound care. R3 R3 admitted to the licensee on July 31, 2025, and began receiving assisted living services. R3's diagnosis included leukemia. R3's unsigned service plan indicated R3 received assistance with activities, ambulation, bathing, catheter care, dressing, finances, grooming, housekeeping, medication administration, meals, vital sign monitoring, shopping, toileting, transfers, and transportation. On November 17, 2025, between 9:20 a.m. and 10:12 a.m., during the entrance conference with owner (O)-A and clinical nurse supervisor (CNS)-C, O-A stated CNS-C worked as a	0 495			

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0 495	Continued From page 16 registered nurse at a hospital and worked on the neurology, urology, post spine, and brain floor. O-A stated the licensee had no additional nurses. O-A stated the on-call nurse was able to be reached via telephone and the expected return time frame for the on-call nurse to call back was two hours. CNS-C stated they were a floor nurse at a hospital on the neuroscience floor. CNS-C stated when they were in a patient's room at the hospital, they were unable to respond to the licensee however, they wore a watch which showed them their text messages and they carried their phone on them. CNS-C stated they would return the phone call as soon as they exited the patient's room. CNS-C stated they have not had any issues getting back to the licensee when called. On November 17, 2025, at 11:21 a.m., CNS-C stated they worked day and night shift rotating, 60 hours per pay period at the hospital. On November 17, 2025, at 11:24 a.m., unlicensed personnel (ULP)-B stated if they needed to speak to an on-call nurse they called CNS-C's phone number. ULP-B stated if CNS-C did not answer the phone call they would send them a text message of the issue they were having at the facility. ULP-B stated CNS-C normally got back to them in 30 to 45 minutes to let them know what they needed to do with the situation. The licensee's 6.12 Availability of an RN for Staff policy dated January 1, 2024, indicated the licensee had a RN available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. The RN must be readily available either in person, by	0 495			

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0 495	Continued From page 17 telephone, or by other means to staff at times when the staff were providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 510			

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0 510	Continued From page 18 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 November 18, 2025, at 7:19 a.m., the surveyor observed ULP-B, with gloves on, cleanse R1's buttock and perineal region with wipes and then remove their gloves. Without performing hand hygiene, ULP-B applied a new pair of gloves, washed R1's back and buttock region with a washcloth, applied lotion to R1's back, buttock, and legs, placed a new incontinent brief under R1, and rolled R1 to the opposite side. ULP-B pulled the brief through to the other side of R1 and then laid R1 flat on their back, pulled the brief in-between R1's legs, applied lotion to the front side of R1's body, applied baby powder to the perineal area, attached the tabs of R1's incontinent brief, applied socks to R1, moved the wheelchair next to R1's bed, and removed their gloves. Without performing hand hygiene, ULP-B applied another new pair of gloves, retrieved R1's nightgown, dressed R1 in a night gown, applied a gait belt to R1, positioned R1 to sit at the edge of the bed, transferred R1 to the wheelchair, combed R1's hair, and removed their gloves. Without performing hand hygiene, ULP-B pushed R1 in their wheelchair to the common area, where they then washed their hands. On November 18, 2025, at 8:37 a.m., the surveyor observed ULP-B in R2's room with gloves already on, complete suprapubic catheter cares, irrigate a suprapubic catheter, open a saline bottle and place the saline into a canister, and remove their gloves. Without performing hand hygiene, ULP-B applied a new pair of gloves, obtained a new piston syringe, and drew	0 510			

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0 510	Continued From page 19 back a syringe of normal saline. ULP-B stated they observed sediment in the syringe from the saline solution and was not going to continue with the irrigation until new solution could be obtained. ULP-B discarded the syringe, and the surveyor exited the room. On November 18, 2025, at 12:24 p.m., ULP-B stated the nurse trained them on infection control at an in-person training and then the nurse watched them perform cares after the training. ULP-B stated the nurse would provide feedback if there were any concerns. On November 19, 2025, at 10:23 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained to wash hands or sanitize hands after removing gloves. CNS-C stated they completed monthly supervisions with the ULP and would address infection control issues if seen. The Centers for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended to clean your hands: - immediately before touching a patient; - before performing an aseptic task such as placing and indwelling device or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or patient's surroundings; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. The licensee's 8.07 Gloves policy dated February 25, 2025, indicated once used gloves were disposed in the proper receptacle hands should	0 510			

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0 510	Continued From page 20 be rewashed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 630			

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0 630	Continued From page 21 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's diagnoses included spastic quadriplegic (paralysis of all four limbs) cerebral palsy, cellulitis of bilateral lower extremities, major depressive disorder, neuromuscular dysfunction of the bladder, chronic pain, post-traumatic stress disorder, and diabetes. R2's Service Plan signed May 3, 2024, indicated R2 received assistance with medication administration, treatments, bathing, grooming, dressing, toileting, laundry, and housekeeping. R2's Individual Abuse Prevention Plan dated October 30, 2025, indicated R2 was at risk to be abused, staff were educated on vulnerable adult abuse, and safety precautions were in place. R2's IAPP lacked an assessment of the resident's risk of abusing other vulnerable adults. R3 R3 admitted to the licensee on July 31, 2025, and began receiving assisted living services. R3's diagnoses included leukemia. R3's unsigned service plan indicated R3 received assistance with activities, ambulation, bathing, catheter care, dressing, finances, grooming, housekeeping, medication administration, meals, vital sign monitoring, shopping, toileting, transfers, and transportation.	0 630			

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0 630	Continued From page 22 R3's Individual Abuse Prevention Plan dated September 14, 2025, indicated R3 was at risk to be abused and there was a risk management in place. R3's IAPP lacked an assessment of the resident's risk of abusing other vulnerable adults and lacked a statement of the specific measures to be taken to minimize the risk of abuse to R3. On November 18, 2025, at 1:43 p.m., the surveyor requested to see the risk management documentation for R3. Clinical nurse supervisor (CNS)-C stated, " I can look it up." CNS-C stated every resident was a vulnerable adult, and residents and staff were trained to recognize signs of abuse. The surveyor did not receive R3's risk management documentation prior to the end of the survey. On November 19, 2025, at 12:28 p.m., CNS-C stated abuse questions were built into their assessments in RTasks (a documenting software program). CNS-C stated when they complete a new assessment the information from the previous assessment populated into the new assessment and sections may grey out. CNS-C stated they must have missed clicking on questions in R2 and R3's assessment that they were not at risk to abuse others. The licensee's 6.05 Individual Abuse Prevention Plan policy dated January 1, 2024, read, "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630			

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0 630	Continued From page 23 and other vulnerable adults." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of	0 650			

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0 650	Continued From page 24 three employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: CNS-C CNS-C was hired on April 19, 2024, to provide supervision to ULP and to provide assisted living services. CNS-C's employee record lacked documentation of an annual performance review that identified areas of improvement and training needs. On November 18, 2025, at 6:56 a.m., owner (O)-A stated the licensee completed performance evaluations via RTasks (a documenting software company). O-A stated prior to the licensee using RTasks they used a paper form for performance evaluations, but they had not completed a performance evaluation for CNS-C. The licensee's 4.35 Employee Evaluation dated January 1, 2024, indicated all staff of the licensee would be given and employee evaluation at least annually. ULP-B ULP-B was hired on July 18, 2023, to provide	0 650			

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0 650	Continued From page 25 assisted living services. On November 18, 2025, at 8:37 a.m., the surveyor observed ULP-B perform suprapubic site care and irrigation for R2. ULP-B's employee record included a document titled 2.16 Foley & suprapubic Catheter Care dated June 3, 2025. The document included a competency evaluation for foley catheter care and suprapubic catheter care with general tube site care, emptying of catheter bag, and leg bag care. ULP-B's employee record lacked documentation of training and a competency evaluation related to suprapubic catheter irrigation. On November 18, 2025, at 12:24 p.m., ULP-B stated CNS-C came to the facility for a "couple of days" and trained them on suprapubic irrigation. ULP-B stated CNS-C then watched them complete the task. ULP-B stated if they made an error when they were completing the task they would be corrected by the nurse and would receive additional training. On November 19, 2025, at 9:14 a.m., ULP-B stated the nurse had them sign a piece of paper after they completed suprapubic catheter training. On November 19, 2025, at 9:40 a.m., CNS-C reviewed with the surveyor the technique they used for suprapubic irrigation. CNS-C stated all ULP were trained and competency evaluated on suprapubic irrigation. CNS-C stated they believed they filled out a competency evaluation form when the competency evaluation was completed. The surveyor explained the form they received and reviewed did not include catheter irrigation. CNS-C stated they understood, however,	0 650			

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0 650	Continued From page 26 asserted they did complete catheter irrigation with each ULP. The licensee's 4.05 Employee Records policy dated January 1, 2024, indicated employee records would include records of all training and in-service education required and/or provided including competency testing as required and documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680			

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0 680	Continued From page 27 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated September 2022, lacked evidence of the following required content: - annual update; - strategies for addressing staffing surges and shortages; - quarterly missing resident plan review; - subsistence needs for staff and residents; - arrangement with other facilities; - names and contact information; and - emergency officials contact information. On November 20, 2025, at 10:10 a.m., owner (O)-A stated the licensee kept a copy of the EPP	0 680			

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0 680	Continued From page 28 in their computer system. O-A stated the computer file indicated it was last updated January 2025. O-A stated they believed they addressed staff shortages in their staffing plan. O-A stated they reviewed the missing resident policy once per year. O-A stated they did not know why they did not fill in the telephone numbers in the EPP however, they did have the phone numbers in their telephone. O-A stated if residents evacuated from the facility, the residents would go to [name of church] church. The surveyor requested to see their agreement with the church. The surveyor did not receive the documentation of the agreement the licensee and the church had prior to the end of survey. The licensee's 9.01 Emergency Preparedness Plan- Appendix Z Compliance policy dated January 1, 2024, read, "It is the intent that [the licensee] has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	0 775			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2025
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0 775	Continued From page 29 Based on observation and interview, the licensee failed to provide egress windows in compliance with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 18, 2025, the surveyor toured the facility with owner (O)-A. During the tour, the surveyor asked O-A to open the windows in the resident rooms for measurement. The noncompliant measurements were as follows: Resident room 1: The window measured 27 inches clear width, 16 inches clear height, and 432 square inches total open area. Resident room 2: The window measured 35 inches clear width, 15 ¾ inches clear height, and 551 ¼ square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. TIME PERIOD FOR CORRECTION: Immediate	0 775			

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0 780	Continued From page 30	0 780			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 780			

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0 780	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 11/18/2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810			

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0 810	Continued From page 32 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810			

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0 810	Continued From page 33 Environment Inspection Report (PEIR) dated 11/18/2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance	0 940			

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0 940	Continued From page 34 waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Residency Contract/Agreement indicated the resident may be eligible to receive certain public funds to assist them in paying for or reducing the cost of the residents rent or service and the licensee participated in certain programs throughout Hennepin County. Residents should contact the director of the licensee to receive additional information related to availability of public funds or contact the Hennepin County department of human services and public health. A resident may be able to obtain Medicare covered home services however if a resident had long term care insurance the licensee could not bill directly, and the resident would have to pay the licensee and	0 940			

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0 940	Continued From page 35 seek reimbursement from the long-term care insurance company. In addition, the licensee provided additional telephone numbers of resources to assist a resident who needed consultation or assistance for evaluation resident housing and resident service needs. The Residency Contract/Agreement lacked the licensee's information on a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04 sub. 2 paragraph (b); - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program and if so the length of time that private pay is required; - a statement that medical assistance waivers provide payment for services but do not cover the cost of rent; - a description of the rent requirement for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; On November 20, 2025, at 9:55 a.m., owner (O)-A stated the document listed above was used for all residents who resided in the facility. O-A stated they were not aware of the requirement. In addition, O-A stated the licensee accepted elderly waiver, community access for disability inclusion (CADDI) waiver, brain injury waiver, and medical	0 940			

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0 940	Continued From page 36 assistance. O-A stated they did not participate in housing support programs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 970			

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0 970	Continued From page 37 The licensee's blank Residency Contract/Agreement included the following section which contained language waving the licensee's liability for health, safety, or personal property of a resident: " INDEMNIFICATION Resident will indemnify and hold harmless Landlord, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Landlord's property, or caused wholly or in part by an act or omission of Resident or Resident's guest or agents." On November 20, 2025, at 9:55 a.m., owner (O)-A stated the document listed above was used for all residents who resided in the facility. O-A stated they were not aware of the requirement. O-A stated they purchased the contract from a consultant after the licensee's previous survey and they believed the contract would be accurate to the assisted living statues since it was purchased. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060			

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01060	Continued From page 38 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident 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			

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01060	Continued From page 39 Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's diagnoses included spastic quadriplegic (paralysis of all four limbs) cerebral palsy, cellulitis of bilateral lower extremities, major depressive disorder, neuromuscular dysfunction of the bladder, chronic pain, post-traumatic stress disorder, and diabetes. R2's Service Plan signed May 3, 2024, indicated R2 received assistance with medication administration, treatments, bathing, grooming, dressing, toileting, laundry, and housekeeping. R2's progress notes dated August 1, 2025, through November 19, 2025, indicated R2 was sent to the hospital on October 24, 2025, for pain	01060			

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01060	Continued From page 40 to their abdomen and not having a bowel movement in three days and refusing alternative treatment options for symptom management that facility could provide. R2 returned to the licensee's facility on October 30, 2025. R2's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On November 19, 2025, at 12:39 a.m., clinical nurse supervisor (CNS)-C stated when a resident was sent to the hospital, they wrote a progress note on what occurred and updated the family and doctor. CNS-C stated they have never completed an emergency relocation notice, they did not know what an emergency relocation notice was, and they did not know what an ombudsman was. On November 19, 2025, at 1:50 p.m., owner (O)-A stated they have never issued an emergency relocation notice for anyone who has been sent to the hospital. O-A stated they believed an emergency relocation notice was needed only if the residents were evacuated from the facility. The licensee's 1.23 Emergency Relocation policy dated January 3, 2025, indicated in the event of an emergency relocation the licensee would provide a written notice that contained at minimum: - the reason for relocation; - the name and contact information for the location to which the resident has been relocated	01060			

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01060	Continued From page 41 and any new service provider; - contact information for the Office of Ombudsman for Long-term Care and Office of Ombudsman for Mental Health and Developmental Disabilities - if know 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 - a statement that if the facility refuses to provide housing or service after relocation the resident had the right to appeal. In addition, the policy indicated the notice would be delivered to OOLTC if the resident has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	01640			

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01640	Continued From page 42 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to finalize a current written service plan that included a signature or other authentication by the facility and by the resident documenting an agreement on the services to be provided for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 The findings include: R2 R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's diagnoses included spastic quadriplegic (paralysis of all four limbs) cerebral palsy, cellulitis of bilateral lower extremities, major depressive disorder, neuromuscular dysfunction of the bladder, chronic pain, post-traumatic stress disorder, and diabetes.	01640			

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01640	Continued From page 43 On November 18, 2025, at 8:37 a.m., the surveyor observed ULP-B perform a suprapubic site care and irrigation on R2. R2's Service Plan signed May 3, 2024, indicated R2 received assistance with medication administration, treatments once daily, bathing, grooming, dressing, toileting, laundry, and housekeeping. R2's unsigned service plan printed November 17, 2025, indicated R2 received assistance with activities, ambulation, bathing, catheter care, dressing, grooming, housekeeping, incontinent care, medication administration, positioning, meals, vital sign monitoring, blood glucose monitoring, shopping, transfers, and wound care. R2's service plan lacked authentication by the resident, or their representative, documenting agreement on the services to be provided when revisions occurred. R3 R3 admitted to the licensee on July 31, 2025, and began receiving assisted living services. R3's diagnoses included leukemia. R3's unsigned service plan indicated R3 received assistance with activities, ambulation, bathing, catheter care, dressing, finances, grooming, housekeeping, medication administration, meals, vital sign monitoring, shopping, toileting, transfers, and transportation. R3's service plan lacked authentication by the resident, or their representative, documenting agreement on the services to be provided. On November 17, 2025, at 11:45 a.m., owner	01640			

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01640	Continued From page 44 (O)-A stated the licensee used to use a paper format service plan however, the licensee switched to RTasks (a documenting software system) for completing service plans. O-A stated the service plan in RTasks did not contain a signature line, so they assumed a signature was not needed. Although R2 had a previously signed service plan, O-A stated R2 and R3 did not have a current signed service plan because they admitted to the facility after they changed their system. On November 19, 2025, at 9:31 a.m., O-A stated they just saw in RTasks where the signature line was in the service plan. O-A stated they believed RTasks recently added the feature. On November 19, 2025, at 12:33 p.m., clinical nurse supervisor (CNS)-C stated a resident's service plan was based off of what was ordered for the resident by the prescriber and what services were provided to the resident. CNS-C stated they have not had any residents sign a service plan however, they believed administration completed the service plan once the resident assessment was completed. The licensee's 6.08 Service Plan policy dated January 1, 2024, indicated the service plan and any revision shall include a signature or other authentication by the licensee and by the resident or resident representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01650	Continued From page 45	01650			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for one of three residents (R3). This practice resulted in a level two violation (a	01650			

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01650	Continued From page 46 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: R3 admitted to the licensee on July 31, 2025, and began receiving assisted living services. R3's diagnosis included leukemia. R3's unsigned service plan indicated R3 received assistance with activities, ambulation, bathing, catheter care, dressing, finances, grooming, housekeeping, medication administration, meals, vital sign monitoring, shopping, toileting, transfers, and transportation. R3's service plan lacked the following content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes the action to be taken if the scheduled service cannot be provided. On November 20, 2025, at 9:16 a.m., clinical nurse supervisor (CNS)-C stated they did not know "100 percent" the content required on the service plan. On November 20, 2025, at 9:55 a.m., owner (O)-A stated the licensee switched from a paper format service plan to one that was built into RTasks (a documenting software program). O-A	01650			

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01650	Continued From page 47 stated they knew the service plan needed to include the service, who provided the service, and how often it was completed. The licensee's 6.08 Service Plan policy dated January 1, 2024, read," 9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: i. Actions Azalea Homes LLC will take if scheduled services cannot be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a	01730			

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01730	Continued From page 48 written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730			

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01730	Continued From page 49 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 The findings include: R2 R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's diagnoses included spastic quadriplegic (paralysis of all four limbs) cerebral palsy, cellulitis of bilateral lower extremities, major depressive disorder, neuromuscular dysfunction of the bladder, chronic pain, post-traumatic stress disorder, and diabetes. R2's Service Plan signed May 3, 2024, indicated R2 received assistance with medication administration, treatments once daily, bathing, grooming, dressing, toileting, laundry, and housekeeping. R2's Med Amin Summary - Month dated November 2025 included the following medications:	01730			

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01730	Continued From page 50 - "Epinephrine Inject 0.3 ml [milliliters] as needed (may repeat x 1)"; and - "Glucose Gel (Daily) Give 15 -30 g [grams] by mouth every 15 minutes as needed for blood sugar lower than _". The medication administration record (MAR) lacked specific administration instructions on when glucose gel would be administered and lacked instructions when 15 g would be used vs 30 g. In addition, the MAR lacked an indication for the use of the epinephrine injection. R3 R3 admitted to the licensee on July 31, 2025, and began receiving assisted living services. R3's diagnoses included leukemia. R3's unsigned service plan indicated R3 received assistance with activities, ambulation, bathing, catheter care, dressing, finances, grooming, housekeeping, medication administration, meals, vital sign monitoring, shopping, toileting, transfers, and transportation. R3's Med Amin Summary - Month dated November 2025 included the following medications: - Asperflex pad apply patch to skin once daily as needed for pain; - nystatin cream apply topically to affected areas twice daily as needed; - albuterol sulfate nebulizer solution give one vial via nebulizer every 4 hours as needed up to six times daily; and - triamcinolone cream apply to affected areas twice daily as needed for rash. The MAR lacked specific administration instructions for the location to apply Asperflex pad, nystatin cream, and triamcinolone cream. In	01730			

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01730	Continued From page 51 addition, the MAR lacked and indication for use for albuterol sulfate nebulizer. On November 19, 2025, at 12:34 p.m., clinical nurse supervisor (CNS)-C stated medications were ordered by the prescriber and orders were sent to the pharmacy. CNS-C stated they believed the pharmacy would look at all the prescriber's orders to ensure all instructions were listed. The surveyor inquired why additional instructions were not added to the orders. CNS-C stated they should have verified the orders however, they believed since they came from the pharmacy they would contain all information that was needed for administration. CNS-C stated going forward they would verify the orders listed on the MAR would have all instructions listed. The licensee's 7.03 Medication Management Individualized Plan policy dated January 1, 2024, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be	01770			

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01770	Continued From page 52 done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication setup documentation was accurate for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee employed one licensed nurse. On November 19, 2025, at 11:25 a.m., the surveyor observed the licensee's medication closet and observed multiple pill box organizers that were set up with medications. R1 R1 admitted to the licensee on July 18, 2023, and began receiving assisted living services. R1's Service Plan signed June 21, 2023, indicated R1 needed assistance with homemaking, shopping, appointments, activities, meals, dressing, grooming, bathing, medication management, incontinence, positioning, transfers, and mobility. R1's Med Set up / Review Summary - Month	01770			

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01770	Continued From page 53 dated November 1, 2025, through November 30, 2025, indicated the following medications were set up for administration: cyanocobalamin 1000 micrograms (mcg) daily, guaifenesin 400 milligrams (mg) twice per day, vitamin d3 2000 international unit (IU) daily, alendronate sodium 70 mg once a week on Mondays, Seroquel 25 mg daily, amlodipine 2.5 mg daily, and donepezil 10 mg daily, melatonin 5 mg daily. The medication set up record indicated from November 10, 2025, through November 16, 2025, the medication listed above were set up by unlicensed personnel (ULP). R2 R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's Service Plan signed May 3, 2024, indicated R2 received assistance with medication administration, treatments, bathing, grooming, dressing, toileting, laundry, and housekeeping. R2's Med Setup / Review Summary - Month dated November 1, 2025, through November 30, 2025, indicated the following medications were set up for administration: loperamide 8 mg twice daily, and omeprazole 20 mg daily. The medication set up record indicated from November 10, 2025, through November 16, 2025, the medication listed above were set up by ULP. R3 R3 admitted to the licensee on July 31, 2025, and began receiving assisted living services. R3's unsigned service plan indicated R3 received assistance with activities, ambulation, bathing, catheter care, dressing, finances, grooming, housekeeping, medication administration, meals,	01770			

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01770	Continued From page 54 vital sign monitoring, shopping, toileting, transfers, and transportation. R3's Med Setup / Review Summary - Month dated November 1, 2025, through November 30, 2025, indicated the following medications were set up for administration: calcium D3 600 mg-400 IU two tablets once a day, methocarbamol 500 mg twice daily, vitamin D3 50 mcg daily, amlodipine 5 mg daily, duloxetine hydrochloride capsule 60 mg daily, loperamide 2 mg daily, olanzapine 5 mg twice per day, tamsulosin 0.4 mg, divalproex sodium delayed release 1500 mg daily, and olanzapine 15 mg at bedtime. The medication set up record indicated from November 10, 2025, through November 16, 2025, the medication listed above were set up by ULP. On November 19, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-C stated they set up medications every two weeks and ULP do not set up medications for residents. The surveyor inquired why the medications listed above were signed off as being set up by ULP from November 10, 2025, through November 16, 2025. CNS-C stated they "might" have missed documenting on the medications. ULP-B joined the conversation and stated the medications were set up by the nurse however, when they went to administer the medication RTasks (a documenting software program) required them to click on medication set up. Owner (O)-A stated RTasks makes them click on setup, verify, and administered whenever a medication is administered. O-A stated if the medication set up was not documented prior to administration the ULP would have to click on medication set up in order to document on the medication they were administering. CNS-C stated they believed the documentation error occurred when they went	01770			

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01770	Continued From page 55 from setting up medication every 30 days to every two weeks. The surveyor inquired if the medications were set up by the nurse prior to the ULP administering the medication listed above. CNS-C stated yes. The licensee's 7.08 Medication Management - Administration & Setup dated January 1, 2024, indicated a licensed nurse would correctly and accurately document any medication setup provided. A licensed nurse would set up medications in dosage boxes for the resident, usually on a weekly basis, and would make or direct changes between set ups when necessary. The licensee's 7.09 Medication Management - Dosage Box Setup policy dated January 1, 2024, indicated when the licensed nurse has completed setting up the medications into the dosage box, the set-up was documented on the MAR. Minnesota Statute 144G.08 Subd. 41.Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01890 SS=D	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			

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01890	Continued From page 56 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 discard expired medication and failed to bear the original prescription label with legible information for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 November 19, 2025, at 11:25 a.m., the surveyor observed an expired albuterol sulfate inhalation aerosol inhaler with an expiration date of May 31, 2025, that did not bear a prescription label, located in the licensee's medication closet where unlicensed personnel (ULP) dispensed medication from. The surveyor inquired whose inhaler it was. Owner (O)-A stated the inhaler belonged to R1 and because they were no longer able to take the medication appropriately, their prescription was changed to a nebulizer instead. The surveyor inquired if R1 still had an order for the medication. O-A stated the inhaler was still on R1's medication list and that was why the medication was still in the bin. The surveyor inquired why the medication was still on R1's medication list and why the inhaler was still in the	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER AZALEA HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5857 PERRY AVENUE NORTH CRYSTAL, MN 55429			
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01890	Continued From page 57 medication bin if they were found not appropriate to use the inhaler. O-A stated they "forgot to take it off." The licensee's 7.23 Medication Disposal policy dated January 1, 2024, indicated expired medications managed by the licensee would be disposed of according to the accepted practices of the Minnesota board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910			

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01910	Continued From page 58 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of medications being managed by the licensee when the resident's medication management services ended for one of one resident (R4). 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: R4 discharged from the licensee's facility on December 21, 2024. R4 was deceased. R4's Service Plan signed June 29, 2024, indicated ULP administered medications to R4 six times per day. R4's Med Admin Summary- Month dated December 2024, indicated R2 received the following medications: loperamide 2 milligrams (mg), ondansetron hydrochloride 8 mg, oxycodone 5 mg, Robitussin 5 to 10 milliliters (ml), senna tablet, gabapentin 100 mg, albuterol inhaler, Compazine tablet, lactase tablet, ibuprofen tablet, Icy Hot Cream, latanoprost 0.005 percent (%), Lomotil 2.5- 0.025 mg, mycophenolate mofetil 500mg, omeprazole delayed release (DR) 20 mg, refresh plush 0.5 % eye drop, Remeron 7.5 mg, soluble fiber powder therapy, triamcinolone ointment 0.1 %,	01910			

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01910	Continued From page 59 acetaminophen 500 mg. ammonium lactate lotion 12 %, atorvastatin 20 mg, brimonidine 0.15 % eye drop, calcium antacid chewable, diclofenac gel 1%, dorzolamide hydrochloride(HCL)/ timolol meleate 2%-0.5% eye drop, famotidine 20 mg, hydroxyzine 25 mg, ipratropium nasal spray 0.3%, Trelegy Ellipta 100 mg, loratadine 10 mg, mitigare capsule, sertraline 100 mg, amlodipine 5 mg, aspirin 81 mg, daily-Vite tablet, fluticasone nasal spray 50 micrograms (mcg), and hydroxychloroquine 200 mg. On November 19, 2025, at 12:44 p.m., the surveyor inquired if clinical nurse supervisor (CNS)-C completed a medication disposition for R4. CNS-C stated they had not completed a medication disposition for R4's medications because they had not destroyed the medication yet. CNS-C stated the medication had not been destroyed because there was only one nurse employed at the facility, and they needed two for the destruction. CNS-C stated the medications were located in a locked cabinet in the laundry room. On November 19, 2025, at 1:45 p.m., the surveyor observed two medium sized cardboard boxes filled with multiple medications locked in a cabinet in the laundry room. The licensee's 7.23 Medication Disposal policy dated January 1, 2024, indicated medications for a resident who was deceased or that have been discontinued or expired may be provided for disposal. The licensee shall dispose of any medications remaining with the facility that are discontinued or expired upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medication and controlled	01910			

Minnesota Department of Health

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01910	Continued From page 60 substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940			

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01940	Continued From page 61 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of one resident (R2) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's diagnoses included spastic quadriplegic (paralysis of all four limbs) cerebral palsy, cellulitis of bilateral lower extremities, major depressive disorder, neuromuscular dysfunction of the bladder, chronic pain, post-traumatic stress disorder, and diabetes. R2's Service Plan signed May 3, 2024, indicated R2 received assistance with medication administration, treatments once daily, bathing, grooming, dressing, toileting, laundry, and housekeeping. R2's unsigned service plan printed November 17,	01940			

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01940	Continued From page 62 2025, indicated R2 received assistance with activities, ambulation, bathing, catheter care, dressing, grooming, housekeeping, incontinent care, medication administration, positioning, meals, vital sign monitoring, blood glucose monitoring, shopping, transfers, and wound care. On November 18, 2025, at 8:37 a.m., the surveyor observed unlicensed personnel (ULP)-B perform suprapubic catheter site care (medical device used to drain urine from the bladder through a small incision in the abdomen) and irrigation on R2. R2's prescriber orders signed March 17, 2025, included "Catheter care: Staff to flush using 110 mL [milliliters] of Normal Saline and 1 piston syringe twice daily and PRN [as needed] as needed for occlusions. Notify RN with any concerns." R2's Service Recap Summary- Month dated November 2025 indicated catheter care was scheduled during the overnight, at bedtime, two times on PM shift, and three times on AM shift. No further instructions were noted on the document. R2's Assessment dated October 30, 2025, indicated the following: - suprapubic stoma irrigation as needed; and - suprapubic catheter in place, irrigation as needed per provider order. Assess for any signs of infection. On November 19, 2025, at 9:14 a.m., ULP-B stated there was no documentation they could view for specific information on when to contact a nurse related to R2's suprapubic catheter however, the nurse did train them to watch for	01940			

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01940	Continued From page 63 signs of infection and report any signs of infection to the nurse. ULP-B showed the surveyor a pop-up window located in the RTasks system (a documenting software program) that read, "Catheter care: Staff to flush using 110 ml of Normal Saline and 1 piston syringe twice daily and PRN as needed for occlusions. Notify RN with any concerns." Although it read to notify a RN with any concerns, it did not provide the ULP specific suprapubic catheter concerns or complications to watch for. R2's treatment and therapy record comprised of multiple documents lacked procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose specifically with catheter irrigation. On November 19, 2025, at 12:28 p.m., CNS-C stated they did not know specific instructions of when a ULP would contact the nurse related to catheter irrigation needed to be in place. The licensee's 7.05 Treatment & Therapy Management Plan dated January 1, 2024, indicated the licensee would develop and maintain a current individualized treatment therapy management record for each resident which must contain procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

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02310	Continued From page 64	02310			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R1, R2) who utilized bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on July 18, 2023, and began receiving assisted living services. R1's diagnoses included Alzheimer's disease and osteoporosis with pathological fracture presence. R1's Service Plan signed June 21, 2023, indicated R1 needed assistance with homemaking, shopping, appointments, activities, meals, dressing, grooming, bathing, medication	02310			

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02310	Continued From page 65 management, incontinence, positioning, transfers, and mobility. On November 18, 2025, at 7:19 a.m., the surveyor observed a hospital bed with bilateral half rails firmly attached to R1's bed. R1's record included a Bed Rail Consent form dated September 21, 2025. R1's Home Restraint / Entrapment Assessment Form dated September 21, 2025, indicated R1 had a half bed rail. The assessment assessed R1's mobility, transfer, fall risk, cognitive function, behaviors, and health status. It indicated R1's bed rail was not a restraint, and the device was recommended for use. In addition, the assessment included zone 1 through 4 measurements that met the Food and Drug Administration (FDA) guidelines and potential risks for using the bed rail. R1's Assessment dated September 21, 2025, indicated the following: - R1 had and electric bed with bilateral bed rails in place to assist with repositioning, bed mobility, and transfers; - bed rails were appropriate for use; - there was no history of injury related to bed rails; - the bed safety zone was not applicable, either bed resident has no bed rails in use or has portable rails that are installed on a consumer bed; and - the bed rail met FDA guidelines. R1's bed rail assessment comprised of two documents lacked the following required information: - record of routine assessment that the bed rail had not shifted and was securely attached to the	02310			

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02310	Continued From page 66 bed frame per manufacturer recommendations. R2 R2 admitted to the licensee on April 3, 2024, and began receiving assisted living services. R2's diagnoses included spastic quadriplegic (paralysis of all four limbs) cerebral palsy, cellulitis of bilateral lower extremities, major depressive disorder, neuromuscular dysfunction of the bladder, chronic pain, post-traumatic stress disorder, and diabetes. R2's Service Plan signed May 3, 2024, indicated R2 received assistance with medication administration, treatments, bathing, grooming, dressing, toileting, laundry, and housekeeping. On November 18, 2025, at 8:37 a.m., the surveyor observed a hospital bed with bilateral full bed rails firmly attached to R2's bed. R2's record included a Beside Rail Consent Form dated August 1, 2024. R2's Home Restraint / Entrapment Assessment Form dated October 30, 2025, indicated R2 had a half bed rail. The assessment assessed R2's mobility, transfer, fall risk, cognitive function, behaviors, and health status. It indicated R2's bed rail was not a restraint, and the device was recommended for use. In addition, the assessment included zone 1 through 4 measurements that met the FDA guidelines and potential risks for using the bed rail. R2's Assessment dated October 30, 2025, indicated the following: - R2 used a standard bed with half rails that were intact and met the resident's needs;	02310			

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02310	Continued From page 67 - bed rails were not a restraint; - R2 was not at high risk for injury if bed rails were in use; - R2 has not had previous injury related to bed rails; - R2 was on two medications that could affect mental status related to use of bed rails; - bed rail zone 1 was less than 4 ¾ inches - bed rail zone 2 was less than 4 ¾ inches. R2's bed rail assessments did not accurately describe R2's current bedrail device. In addition, R2's bed rail assessment comprised of two documents lacked the following required information: - record of routine assessment that the bed rail had not shifted and was securely attached to the bed frame per manufacturer recommendations. On November 19, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-C stated bed rail assessments were completed quarterly or every six months. CNS-C stated the bed rail assessment was located in RTasks (a documenting software system) and when a new assessment was created it would populate the information from the previous assessment into the new assessment. CNS-C stated they might have skipped over some questions in the RTasks assessment because they were greyed out. CNS-C stated their practice was they complete the resident's first bed rail assessment on paper to ensure bed rail measurements were correct. CNS-C stated they do not look at the manufacturer's instruction for the bed rails and they base if the bedrail is safe for use off of the bed rail measurements. CNS-C stated their bed rail assessments did not address if the bed rail was securely attached to the bed frame.	02310			

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02310	Continued From page 68 On November 19, 2025, at 10:10 a.m., CNS-C stated R2 had full bed rails. CNS-C stated R2 has never had half bed rails and it was a documentation error that R2's bed rail assessment was marked with half rails. CNS-C stated the assessment may have been mismarked with the other resident's bed rail type because they had two residents with bed rails. The Minnesota Department of Health's (MDH) Assisted Living Resources and Frequently Asked Questions (FAQs) dated October 13, 2025, indicated a licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's 6.28 Side Rails policy dated January 1, 2024, indicated the licensee would verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The licensee would determine if the side rail was considered to be safe by meeting all of the requirements listed below: - the side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. - the side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. - the side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4.75". No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			

Minnesota Department of Health

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Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Azalea Homes LLC
5857 Perry Avenue N
Crystal, MN 55428
Hennepin County
Parcel:

Phone:
WECARE@AZALEAHOMES.ORG

License Info

License: 0042198

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Siamah Kanneh
CFPM #: 15614; Exp: 05/01/2026

Inspection Info

Report Number: F8044251271
Inspection Type: Full - Single
Date: 11/17/2025 Time: 10:22:04 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: Rinse cycle in dishwasher measured at 117 degrees F.

Continue to use tubs to sanitize dishes until a new dishwasher is installed.

Comply By: 1/16/2026 Originally Issued On: 11/17/2025

! New Order: 7-200 Toxic Supplies and Applications

7-204.11 Priority Level: Priority 1 CFP#: 28

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT: Low-splash bleach and ZEP used on counters is not approved for food contact surfaces.

Comply By: 11/17/2025 Originally Issued On: 11/17/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator, Ashley Crews. Inspection report reviewed on site with Cece.

Domestic kitchen consists of vinyl flooring, wooden hollow-based cabinets, laminate counters, tiled walls, painted gypsum walls and ceilings, and domestic equipment.

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 Rochester District Office inspection report number F8044251271 from 11/17/2025

Cece Kanneh
Owner


Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

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Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

Azalea Homes LLC
Crystal
County/Group: Hennepin County

Inspection Info

Report Number: F8044251271
Inspection Type: Full
Date: 11/17/2025
Time: 10:22:04 AM

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

Location: Refrigerator at 38.8 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Refrigerator at 39.0 Degrees F.

Comment:

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info	Inspection Info
Azalea Homes LLC	Report Number: F8044251271
Crystal	Inspection Type: Full
County/Group: Hennepin County	Date: 11/17/2025
	Time: 10:22:04 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 116.8 Degrees F.
Comment:
Violation Issued?: Yes

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39267016	Date: 11/18/2025
Facility Name: Azelea Homes LLC	
Facility Address: 5857 Perry Avenue North Crystal, MN 55429	

☒ **TAG IDENTIFICATION:** 0780

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

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

Comments: The smoke alarm in resident room 1 would not sound when owner (O)-A attempted to test the smoke alarm. The smoke alarm in resident room 2 was only sounding locally and was not interconnected with the rest of the smoke alarms in the facility.

☒ **TAG IDENTIFICATION:** 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronyms R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and P.A.S.S (Pull, Aim, Squeeze, and Sweep). The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems.

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

Comments: The FSEP did not identify specific fire protection actions for residents. The resident fire safety & evacuation training sheet contained instructions to residents to stay calm, listen to staff instructions, staff will come to your room and help you leave safely, and that if you cannot evacuate quickly staff may move you to a safe room away from the fire. Shelter-in-place strategies are not appropriate in the event of a fire or similar emergency in buildings that are not equipped throughout with life safety systems or fire resistant construction types.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.