Electronically Delivered

June 18, 2025

Licensee
Norbella of Rogers
21900 South Diamond Lake Road
Rogers, MN 55374

RE: Project Number(s) SL39481015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 9, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY

Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

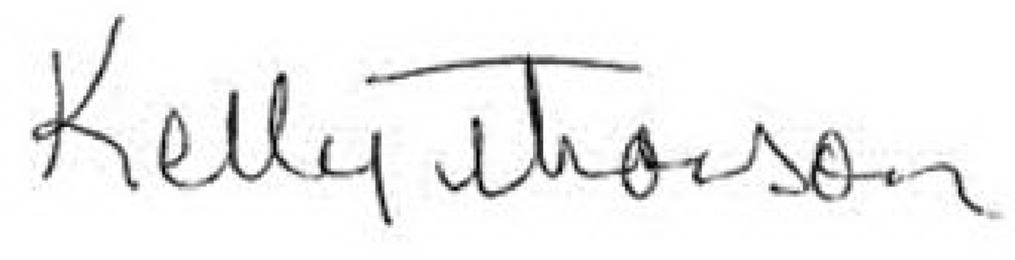
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39481	A. BUILDING: _____ B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF ROGERS	21900 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39481015-0 On May 5, 2025, through May 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 18 resident(s); all of whom were receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by one of three employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A began providing cares to the residents on January 3, 2025. On May 6, 2025, from 7:12 a.m., through 7:30 a.m., during continous observation surveyor observed ULP-A provide morning cares to R6.	0 510		

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0 510	Continued From page 2 ULP-A went into R6;s room and without preforming hand hygiene donned gloves. ULP-A removed R6's socks and pants, then removed a urine soiled brief. Without preforming hand hygiene ULP-A doffed gloves and donned a new pair of gloves. ULP-A assisted another Ulp with putting a new brief on R6 and then applied barrier cream to R6. ULP-A then doffed the soiled gloves and without preforming hand hygiene donned clean gloves. ULP-A emptied R6's garbage, doffed gloves and washed hands. On May 6, 2025, at 11:35 a.m., ULP-A stated, "After peri care you should wash your hands, and we are supposed to change gloves after touching fluids or getting contaminated and then you need to wash your hands after you are done caring for someone." On May 6, 2025, at 12:20 p.m., clinical nurse supervisor (CNS)-D indicated all staff were training on hand hygiene and gloving at their coorporate training and stated, "As far as wearing gloves, the staff need to wear gloves every time they are coming into contact with bodily fluids or doing cares, they need to take them off between residents and do their hand hygiene and put new ones on." The licensee's Gloving policy, dated February 2021, indicated, "Gloves must be changed between different cares along with proper hand washing/disinfecting to prevent cross-contamination; this includes changing cares for the same tenant (example: going from toileting to oral care, new gloves and hand hygiene must be performed). Discard gloves properly after each individual use. Wash hands after use of gloves."	0 510		

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0 510	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two resident's (R6 and R7) personal health and medical information was kept private. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 6, 2025, from 7:00 a.m. to 7:06 a.m., surveyor observed the unlicensed personnel (ULP)-A walk away from the charting computer to	0 700		

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0 700	Continued From page 4 attend to other tasks in another area of the secured unit. The computer screen was left open displaying R7's medical information. The surveyor observed two resident and one staff that was not responsible for medications, pass directly by the unattended laptop that was located in an open and accessible common area. On May 6, 2025, from 7:33 a.m., to 7:40 a.m., surveyor observed ULP-A verify R6's medications. ULP-A then left R6's medical information including residents name and medications open on the computer charting system while ULP-A proceeded to another area of the facility to administer medications to R6. The surveyor observed two residents to be present in the commons area where the computer was left unattended. On May 6, 2025, at 11:41 a.m., ULP-A stated, "Immediately when I am done with documentation I am to shut it down, I normally do it, but I must have forgot today." On May 6, 2025, at 12:22 p.m., clinical nurse supervisor (CNS)-D stated, "They should lock computer screens and for sure put it down so not everyone can see." The licensee's Safeguarding PHI Stored on the Computer System policy, dated April 2003, indicated, "It is the policy of this organization to protect the confidentiality of all computer based health information by setting up access controls and physical safeguards. GUIDELINES FOR PHYSICAL ACCESS TO COMPUTERS 1. Physical access to computer workstations or terminals should be limited to staff requiring their use.	0 700		

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0 700	Continued From page 5 2. Computer screen placement should be reviewed periodically to ensure that unauthorized viewing is not easily possible. 3. The facility staff should be trained to log off their workstation when leaving the work area and this should be monitored periodically." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 775		

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0 775	Continued From page 6 On May 7, 2025, from 9:30 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-C. The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: FIRE RESISTANT RATED DOORS The fire-rated cross-corridor doors adjacent to apartment 122 and adjacent to the employee break room did not close and latch. Fire-resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency in accordance with Minnesota State Fire Code. LALD-C visually verified these deficient findings at the time of discovery. On May 7, 2025, LALD-C stated they did not realize the doors listed above did not latch and would get them repaired as soon as possible. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 7 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 8 The findings include: On May 7, 2025, licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drill Evaluation Form", multiple dates, indicated evacuation drills were conducted on November 15, 2024, January 31, 2025, and April 1, 2025. No other documentation was provided. On May 7, 2025, at 1:30 p.m., LALD-C stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01060		

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01060	Continued From page 9 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: 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 for one of one resident (R4). This practice resulted in a level two violation (a	01060		

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01060	Continued From page 10 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 was admitted to the licensee and began receiving assisted living services on January 9, 2025. R4's records included a progress note dated May 2, 2025, that indicated R4 had been admitted to the hospital from May 2, 2025 through May 4, 2025. R4's record lacked a written notice with the required statutory content provided to the resident or resident representative of the emergency relocation. On May 6, 2025, at 9:03 a.m., clinical nurse supervisor (CNS)-D indicated no emergency relocation form had been completed or sent for R4 and stated, "I don't do them unless they are gone the 4 or more days." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 11 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an admission assessment and a reassessment within 14-days following admission date for one of three residents (R2), and ongoing nursing assessments not to exceed every 90-days thereafter for two of three residents (R2 and 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) and was issued at a	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39481	A. BUILDING: _____ B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF ROGERS	21900 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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
01620	Continued From page 12 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee for assisted living services on February 27, 2025. R2's record included a signed service plan dated, February 27, 2025, that indicated R2 received assistance with bathing, escort services, blood glucose monitoring, toileting, laundry, housekeeping, dressing, medication administration, and transfer assistance. R2's record included an admission assessment and a 14-day assessment that were both signed and dated May 5, 2025 indicating 67 days had passed since admission without a completed assessment. R3 R3 was admitted to the licensee for assisted living services on January 9, 2025. R3 record included a signed service plan dated, that indicated R3 received assistance with medication administration, monthly vitals, laundry, housekeeping, bathing, turning and repositioning, transfer assistance, toileting, oral cares, grooming, and dressing. R3's record included assessments (labeled admission assessments) signed and dated January 3, 2025, and May 6, 2025, indicating 123 days had passed between assessments.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39481	A. BUILDING: _____ B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF ROGERS	21900 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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01620	Continued From page 13 On May 6, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-D stated, "It was me by myself for a long time and I was in survival mode so its possible there are still some unlocked (unsigned) because my focus was just getting them done and I planned to go back and look them over before locking them, and I haven't yet." The licensee's Comprehensive Assessment Schedule dated July 2014, indicated assessments would be completed within 14 days after initiation of services and at least every 90 days thereafter. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39481	A. BUILDING: _____ B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF ROGERS	21900 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

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01650	Continued From page 14 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 three of three residents (R2, R3, R5,). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee for assisted living services on February 27, 2025. R2's record included a signed service plan dated, February 27, 2025, that indicated R2 received assistance with bathing, escort services, blood glucose monitoring, toileting, laundry, housekeeping, dressing, medication	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39481	A. BUILDING: _____ B. WING _____	05/09/2025

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01650	Continued From page 15 administration, and transfer assistance. R3 R3 was admitted to the licensee for assisted living services on January 9, 2025. R3 record included a signed service plan dated, that indicated R3 received assistance with medication administration, monthly vitals, laundry, housekeeping, bathing, turning and repositioning, transfer assistance, toileting, oral cares, grooming, and dressing. R5 R5 was admitted to the licensee for assisted living services on October 14, 2024. R5 record included a signed service plan dated, February 27, 2025, that indicated R5 received assistance with bathing, denture care, monthly vitals, grooming, hearing aids, laundry, housekeeping, toileting, dressing, medication administration, and transfer assistance. R2, R3, and R5's service plans lacked - methods of monitoring assessments of the resident; - methods of monitoring staff providing services; - 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; - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; and - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39481	A. BUILDING: _____ B. WING _____	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01650	Continued From page 16 change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On May 6, 2025, at 12:35 p.m., clinical nurse supervisor (CNS)-D stated, "I know what you are talking about because I know Rtasks has everything that is needed on the service plans, but that is not something that populates on ours. I can look and see if we have it someplace else, but I am not sure." The licensee's Service Plan policy, dated March 2015, indicated the service plans would include the above mentioned items. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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

Food & Beverage Inspection Report

Establishment Info

Norbella of Rogers
21900 South Diamond Lake Road
Rogers, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39481

Risk:
License:
Expires on:
CFPM: DAVID ALLAN HARRISON
CFPM #: FM15281; Exp: 02/16/2026

Inspection Info

Report Number: F8087251005
Inspection Type: Full - Single
Date: 5/6/2025 Time: 11:00:00AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER DAVID ALLAN HARRISON AND NURSE SURVEYOR TESA BROWN.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND NURSE SURVEYOR TESA BROWN.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans

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

I acknowledge receipt of the Metro District Office inspection report number F8087251005 from 5/6/2025

John Boettcher

DAVID ALLAN HARRISON
KITCHEN MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Norbella of Rogers
Rogers
County/Group: Hennepin County

Inspection Info

Report Number: F8087251005
Inspection Type: Full
Date: 5/6/2025
Time: 11:00:00AM

Equipment Temperature: Product/Item/Unit: ABIENT AIR**; Temperature Process:** Abient Air
Location: Walk-in Freezer at -5 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Abient Air
Location: Walk-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HARD BOILED EGG**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Abient Air
Location: Upright Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT TOMATO**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MASHED SWEET POTATO**; Temperature Process:** Hot-Holding
Location: Steam Table at 164 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** BRAISED PORK LOIN**; Temperature Process:** Hot-Holding
Location: Steam Table at 167 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Norbella of Rogers
Rogers
County/Group: Hennepin County

Inspection Info

Report Number: F8087251005
Inspection Type: Full
Date: 5/6/2025
Time: 11:00:00AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
Location: Dishwashing Area **Equal To** 163 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Prep **Greater Than** 400 PPM
Comment:
Violation Issued?: No