



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 2, 2026

Licensee
Minnesota Greenleaf
1006 Greenwood Street East
Thief River Falls, MN 56701

RE: License Number 418316
Health Facility Identification Number (HFID) 30342
Project Number(s) SL30342016

Dear Licensee:

On January 8, 2026, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed July 18, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 8, 2026.

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.

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

Sincerely,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 22, 2025

Licensee

Minnesota Greenleaf

1006 Greenwood Street East

Thief River Falls, MN 56701

RE: Conditional License Number 418316
Health Facility Identification Number (HFID) 30342
Project Number(s) SL30342016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 18, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, Subd. 1 (a), MDH is issuing a 90-day conditional license, pending appeal under Minn. Stat. § 144G.20, Subd. 18.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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.

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - \$1,000.00
St - 0 - 0420 - 144g.40 Subdivision 1 - Responsibility For Housing And Services - \$1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required S-S - \$1,000.00
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - \$1,000.00
St - 0 - 1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the total amount you are assessed is \$5,500.00 You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders 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. If you request a hearing, please specify whether you are appealing the orders and fines, the

imposed conditions, or both.

CONDITIONAL LICENSE ISSUED:

MDH will issue Minnesota Greenleaf a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Minnesota Greenleaf is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Minnesota Greenleaf will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Minnesota Greenleaf must provide the Department:
 - i. A list of the names and birthdates of any individuals Minnesota Greenleaf is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents:
 1. Name and birthdate of each resident
 2. Current payment source for services
 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Minnesota Greenleaf will contract with an RN to provide consultation concerning all resident(s) to whom Minnesota Greenleaf provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Minnesota Greenleaf. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Minnesota Greenleaf and MDH must review the RN’s credentials and approve the selection. Minnesota Greenleaf is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Minnesota Greenleaf in an effort to help Minnesota Greenleaf align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Minnesota Greenleaf will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Minnesota Greenleaf and the RN consultant about a change. Each report will be electronically submitted to: HRDConsultantReports.MDH@state.mn.us. The content of the reports will include information such as:
 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Minnesota Greenleaf to correct the violations cited during the survey as well as to determine the overall practice of Minnesota Greenleaf in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Minnesota Greenleaf will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Minnesota Greenleaf is in substantial compliance based on the results of the follow up

survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Minnesota Greenleaf is in substantial compliance on the follow up survey, MDH will remove the conditions from Minnesota Greenleaf's assisted living facility license, and Minnesota Greenleaf will correct any outstanding violations identified during the survey. If Minnesota Greenleaf is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

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

If you request a hearing, please specify whether you are appealing the orders and fines, the imposed conditions, or both.

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA GREENLEAF		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701			
(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)	
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: SL30342016-0 On July 14, 2025, through July 18, 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 42 residents; 42 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on July 16, 2025, issued for SL30342016-0, tag identification 0110. The licensee took action on July 16, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I). An immediate correction order was identified on July 16, 2025, issued for SL30342016-0, tag identification 1290. The licensee took action on July 16, 2025, to mitigate the risk; however, the		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 scope and level remains at level 3/Widespread (I). An immediate correction order was identified on July 18, 2025, issued for SL30342016-0, tag identification 1730. The licensee took action on July 18, 2025, to mitigate the risk; however, the scope and level remains at level 3/Isolated (G). An immediate correction order was identified on July 18, 2025, issued for SL30342016-0, tag identification 1620. The licensee took action on July 18, 2025, and July 20, 2025, to mitigate the risk; however, the scope and level remains at level 3/Pattern (H).	0 000			
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD), licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 or a violation that has the potential to lead to 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: This resulted in an immediate correction order issued on July 16, 2025. The licensee held an assisted living facility with dementia care (ALFDC) license issued on November 1, 2024, through October 31, 2025. On entering the facility on July 14, 2025, at 10:45 a.m. ,clinical nurse supervisor (CNS)-B stated a new consultant was hired to mentor the licensee's assisted living director in residency (ALDIR)-A. CNS-B further stated a change in management recently occurred in June 2025. During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated previous LALD-O was listed as the current LALD for the licensee and mentor had worked for the license through the previous management company that is no longer affiliated with the licensee. C-C stated she was hired as a consultant for the facility, and planned to mentor ALDIR-A, however the application was denied and is currently working with BELTSS to resolve the denial. On July 14, 2025, at 3:00 p.m., the BELTSS website indicated previous LALD-O was listed as the director of record for the facility effective October 9, 2024. On July 14, 2025, at 3:03 p.m., the BELTSS	0 110			

Minnesota Department of Health

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0 110	Continued From page 3 website indicated C-C was listed as the director of record for the licensee effective June 8, 2025, and expired July 1, 2025. On July 14, 2025, at 3:05 p.m., the BELTSS website indicated A-N had a shared residency permit effective October 10, 2023, and expired October 9, 2024, for the licensee. On July 15, 2025, at 12:40 p.m., ombudsman (O)-P who was at the facility for a resident council meeting, stated she had been coming to the facility every two weeks for several weeks and was not aware there was a mentor for ALDIR-A. O-P further stated she had never met or seen her at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 110			
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category;	0 130			

Minnesota Department of Health

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0 130	Continued From page 4 (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance	0 130			

Minnesota Department of Health

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0 130	Continued From page 5 fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of	0 130			

Minnesota Department of Health

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0 130	Continued From page 6 accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the definition of an adult, resident and assisted living facility when the licensee had five non-resident individuals (unlicensed personnel (ULP)-R, ULP-M, ULP-F) and two children of ULP-R (ages	0 130			

Minnesota Department of Health

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0 130	Continued From page 7 16 and 18-year-olds) residing at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee's assisted living licensure effective date was November 1, 2024, with an expiration date of October 31, 2025. The surveyor was invited by R5 to a resident council meeting on July 15, 2025, from 12:40 a.m., to 2:00 p.m. During the meeting, residents indicated three staff members had been living at the facility for about a month. Assistant director (AD)-E confirmed ULP-R, ULP-M, ULP-F were staying in an empty apartment on the third floor of the facility. AD-E further stated the three staff did not have a contract signed with the licensee. On July 16, 2025, at 10:17 a.m., R8 stated last evening (July 15, 2025), she had seen four adults and one child in the hallway on the third floor. On July 17, 2025, from 10:30 a.m. to 10:45 a.m., the surveyor and AD-E went to apartment 3006 on the third floor. AD-E stated the prior management company allowed the staff to stay at the apartment, and assisted living director in residence (ALDIR)-A "followed suit". Prior to entering the apartment, a female adult was seen leaving the apartment, once inside 3 adult females and a younger teen male were seen, all	0 130			

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NAME OF PROVIDER OR SUPPLIER MINNESOTA GREENLEAF		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701			
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0 130	Continued From page 8 left the apartment except ULP-R. ULP-R stated she had been living in the apartment for about a month with her sister (ULP-M), and her daughter (ULP-F). Furthermore, ULP-R stated her son and daughter, ages 16- and 18-year-olds, respectively, arrived three days ago. ULP-R stated ULP-R and the others living at the facility did not have a contract with the licensee for the apartment. ULP-R stated they will be moving out on July 28, 2025, as ULP-R had secured an apartment in town. Minnesota Assisted Living Statutes 144G.08 definitions indicated: - Subd. 2. Adult - "Adult" means a natural person who has attained the age of eighteen years. - Subd. 5. Assisted living contract - "Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services;" - Subd. 7. Assisted living facility - "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions. - Subd. 59. Resident. - "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130			
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily accessible to residents and others, including	0 345			

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0 345	Continued From page 9 provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0480, 0510, 900, 1370, 1380, 1420, 1440, 1490, 1750, and 1910) for a survey completed on September 15, 2022. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated the	0 345			

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0 345	Continued From page 10 licensee was familiar with the current minimum assisted living requirements. The licensee provided their corrective action plan from the prior survey completed September 15, 2022, which consisted of two pages including corrections made for tag 0730 and 0800. It did not include documentation for tags 0480, 0510, 900, 1370, 1380, 1420, 1440, 1490, 1750 and 1910. On July 16, 2025, at 9:33 p.m., C-C emailed (electronic communication) the surveyor, "C-C or onsite staff was unable to access the prior survey correction binder". However, C-C was able to locate the correction orders for 0730 and 0800. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345			
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 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 management, control, and operation of the housing and	0 420			

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0 420	Continued From page 11 services provided by 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, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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: During the entrance conference on July 14, 2025, at 12:00 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee held an assisted living license with dementia care license effective November 1, 2024, with an expiration date of October 31, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application	0 420			

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0 420	Continued From page 12 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 (Minnesota Department of Health), in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on October 1, 2024. As a result of this survey, the following orders were issued under 0110, 0130, 0345, 0470, 0480, 0485, 0490, 0620, 0640, 0650, 0660, 0680, 0730, 0775, 0800, 0810, 0900, 1290, 1440, 1540, 1620, 1640, 1730, 1760, 1790, 1820, 1890, 1930, 2040, 2170 and 2320, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans	0 470			

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0 470	Continued From page 13 on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. 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) 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:	0 470			

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0 470	Continued From page 14 The licensee held a dementia care assisted living license effective November 1, 2024, with an expiration date of October 31, 2025. The facility was licensed for a capacity of 71 and had a current census of 42 residents. During the entrance conference on July 14, 2025, from 12:00 p.m. through 12:45 p.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. Furthermore, C-C stated the licensee scheduled the following unlicensed personnel (ULPs) for each shift: -day shift, unsecured unit - 2 ULPs, and secured unit - 3 ULPs; -evening shift, unsecured unit - 2 ULPs, and secured unit 3 ULPs; and -night shift, unsecured unit - 2.5 ULPs, and secured unit 1.5 ULPs. On July 16, 2025, at 10:15 a.m., C-C stated C-C had communicated with the past management company and the licensee did not have a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents:	0 480			

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0 480	Continued From page 15 (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; (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	0 480			

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0 480	Continued From page 16 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 15, 2025 for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485			

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0 485	Continued From page 17 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure weekly menus were made available to the residents at least a week in advance in the secured unit of the facility. This had the potential to affect all 14 residents residing in the secured unit. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 485			

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0 485	Continued From page 18 During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated the licensee provided three meals daily to include fresh fruits and vegetables, snacks were offered, residents had input with menus, and residents were made aware of changes to the menu. During the entrance tour of the secured unit on July 14, 2025, at 12:50 p.m., the surveyor did not observe a posted menu. C-C verified there was not a menu posted in the secured unit. Furthermore, C-C stated a menu should have been posted. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible	0 490			

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0 490	Continued From page 19 for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 42 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated to C-C's understanding the licensee had provided a daily program of social and recreational activity for residents. During the entrance tour on July 14, 2025, from 12:45 p.m. through 1:45 p.m., the surveyor observed white boards (erasable calendars) in the unsecured and secured units. The	0 490			

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0 490	Continued From page 20 whiteboards in the unsecured unit indicated bingo on July 5, 6, and 14. Other past days from July were marked with an X, and July 15 through July 31 were blank. The surveyor observed no other activities written on the whiteboards. In the secured unit, the whiteboards read the same as the unsecured unit. The surveyor observed in the unsecured unit the residents sleeping in chairs, one resident working on a puzzle and a couple residents were visiting. In the secured unit, residents wandered in the hallways, were in their rooms, or were sitting at the tables with no activities. On July 14, 2025, from 2:35 p.m. through 3:00 p.m., the surveyor interviewed R4. R4 stated the facility did not have an activity director and there was no activity calendar for the month of July. R4 stated R4 leads exercise on Mondays, Wednesdays and Fridays, and R5 leads exercises on Tuesdays and Thursdays. Furthermore, R4 stated the exercises are done in the secured unit otherwise, the residents in the secured unit would not participate in exercise. R5 stated R9 or another resident will call bingo when the residents want to play bingo. On July 15, 2025, from 9:00 a.m. through 9:30 a.m., the surveyor interviewed R5. R5 stated R5 was unsure if the facility had an activity director. Furthermore, R5 stated the facility did not have a formal activity program, the activities and exercises were led by residents. On July 16, 2025, at 11:51 p.m., assistant director (AD)-E stated the white boards were the current activities that were planned, however the licensee was working on an activities program. No further information was provided.	0 490			

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0 490	Continued From page 21	0 490			
0 620 SS=E	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above.	0 620			

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0 620	Continued From page 22 (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R1, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a pattern scope (when more than a	0 620			

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0 620	Continued From page 23 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 14, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1 R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD- difficult breathing). R1's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R1's services included medication administration, activity assistance, bathing, grooming, behavior management, dressing, safety checks, and housekeeping. R1's Individual Abuse Prevention Plan dated July 11, 2025, indicated facility will manage all medications, staff to administer all medications, and ensure R1 takes ordered medications. R1's Hospital Nurse Note dated July 9, 2025, at 9:42 p.m., written by registered nurse (RN)-Q indicated R1 was admitted to the hospital with a diagnosis of a urinary tract infection (UTI) and kidney infection. R1's Return Nurse Note dated July 11, 2025, at 12:04 p.m., written by CNS-B indicated R1 returned from the hospital and new medication included Cipro (antibiotic to treat infection) 250	0 620			

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0 620	Continued From page 24 milligrams (mg) by mouth twice daily for UTI. R1's Admission Assessment dated July 11, 2025, completed by CNS-B indicated the facility nurse will verify that all medications are administered as prescribed and monitor of [sic] medication use to prevent possible complications of adverse reactions by competency training and supervising appropriate staff to administer medications. In addition, R1 denied any active genitourinary (GU- kidney and bladder) problems. R1's prescriber orders dated July 11, 2025, included an order for Ciprofloxacin (Cipro) 250 mg by mouth twice daily for six days. R1's Med (medication) Admin (administration) Summary- Actual- Month dated July 2025, indicated the following: -July 12, 13, 14, 15, 16, and 17, respectively, R1 did not receive Cipro 250 mg dose scheduled at 8:00 a.m.; and -July 11, 12, 13, 14, 15, and 16, respectively, R1 did not receive Cipro 250 mg dose scheduled at 8:00 p.m. Unlicensed personnel (ULP) documented R1's Cipro as not administered, not on cart, not in stock, or not on cart DON (director of nursing/CNS) notified. R1's Phone Nurse Note dated July 16, 2025 (five days after Cipro was supposed to be administered), at 4:07 p.m., written by CNS-B indicated phone message to provider/hospital regarding Cipro order from hospital return-pharmacy did not receive order- need further instruction regarding this (Cipro order). R1's record lacked documentation of any	0 620			

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0 620	Continued From page 25 follow-up procedures or interventions provided to meet R1's needs when R1's Cipro 250 mg was not available to be given to R1. In addition, R1's record lacked documentation, which notified R1's physician or family of prescribed Cipro 250 mg not administered to R1 from July 11, 2025, through July 16, 2025. The licensee lacked documentation of a MAARC report for R1's Cipro not being available or administered to R1 from July 11, 2025, through July 17, 2025. On July 17, 2025, at 4:22 p.m., the surveyor left a voicemail for CNS-B to call for an interview, however, the surveyor did not receive a call back. On July 17, 2025, from 4:29 p.m. through 4:38 p.m., the surveyor completed an interview with RN-Q. RN-Q stated RN-Q was informed by CNS-B yesterday (July 16, 2025) R1's Cipro had not arrived at the facility. RN-Q stated CNS-B had tried to call R1's provider multiple times, however, R1's provider had not returned any calls to CNS-B. RN-Q further stated the only note in R1's record regarding contacting R1's provider was July 16, 2025 (five days after Cipro 250 mg was supposed to be administered), at 4:07 p.m. RN-Q stated usually the pharmacy delivered resident's antibiotics right away, ULPs were supposed to notify nursing staff if the antibiotic had not shown up, however, no notification had been made by ULPs to nursing staff. RN-Q further stated RN-Q typically did not go to the facility if a resident needed an assessment, however, RN-Q would contact the resident's family to see if the resident could go to the emergency room to be assessed, otherwise ULPs would just monitor the resident on a case-by-case basis. RN-Q stated to ensure R1 did not get urosepsis (life-threatening	0 620			

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0 620	Continued From page 26 complication of an infection of the urinary system), ULPs would contact RN-Q if R1 reported pain or R1 was not up and walking, nor had the facility instructed ULPs on what specifically to monitor for regarding signs and symptoms of urosepsis. RN-Q stated RN-Q was going to call the facility to check on R1, to see if R1's family wanted R1 to go to the emergency room for antibiotics, or make an appointment for R1 tomorrow (July 18, 2025) to see about R1 receiving Cipro 250 mg. On July 18, 2025, from 8:11 a.m. through 8:18 a.m., the surveyor received a return call from CNS-B for interview. CNS-B stated CNS-B did not realize R1's Cipro hadn't arrived from the pharmacy since R1 returned from the hospital on a Friday and CNS-B does not work on the weekend. CNS-B further stated usually the ULPs will contact the pharmacy for any medication that had not arrived at the facility or contact the nurse on call, however, for "some reason" that (ULPs did not contact the pharmacy or nurse on call) did not happen and it is an "unfortunate" situation. CNS-B stated CNS-B reached out to the provider via telephone and fax on or around July 15, 2025, or July 16, 2025, however, CNS-B would have to pull fax records to know for sure what date CNS-B called and faxed the provider. CNS-B stated when CNS-B completed R1's assessment on July 11, 2025, at 12:03 p.m., CNS-B must have forgot to check the box under genitourinary to include R1 was diagnosed with a bladder infection and kidney infection. CNS-B further stated the facility relies heavily on ULPs to report any changes in resident condition, however, CNS-B stated CNS-B did not put any interventions in place to address ULPs monitoring R1 for urosepsis, such as checking vital signs or R1's temperature. CNS-B stated no additional	0 620			

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0 620	Continued From page 27 assessments were assigned to R1 to assess for a change of condition since the RNs relied on the ULPs to report any change of condition for R1. CNS-B further stated the RN on call over the night and weekends was required to come onsite to the facility to complete a change of condition assessments on residents as needed. R7 R7's diagnosis included Alzheimer's dementia, agitation, and falls. R7's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R7's services included medication administration, activity assistance, bathing, grooming, incontinence management, dressing, compression stockings, safety checks, meal assistance (including feeding), laundry, and housekeeping. R7's assessment dated May 15, 2025, completed by RN-Q indicated the facility nurse will verify that all medications are administered as prescribed and monitor of [sic] medication use to prevent possible complications of adverse reactions by competency training and supervising appropriate staff to administer medications. In addition, R7's behavior indicated R7 can be resistive to cares. R7's progress note (PN) dated June 22, 2025, at 1:54 p.m., by ULP-D indicated R7 aggressive, hitting and swearing. R7's PN dated June 25, 2025, at 11:04 a.m., by CNS-B indicated provider ordered Zyprexa 2.5 milligram (mg) twice daily for aggressive behavior and collect urine.	0 620			

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0 620	Continued From page 28 R7's June 2025 electronic medication administration summary indicated on June 25, 2025, R7 started on Zyprexa dissolving tablet, Take 2.5 mg by mouth daily for aggressive behavior. Take half of 5 mg tablet. Medication was administered: -8:00 a.m. dose: June 26, 27, 28, 29, 30, July 5, 6 [dose indicated as refused, wife refused, or sleeping for July 1-4 and July 7-8] -8:00 p.m. dose: June 26, 27, 28, 29, 30, July 5 [dose indicated as refused, wife refused, or sleeping for July 1-4, and July 6-7] R7's PN dated July 7, 2025, at 7:21 p.m., by RN-Q indicated resident's wife feels medication to much and "snowing" (causing sedation, unresponsiveness) R7. Wife refusing medication for R7. Staff noted medication Zyprexa 5 mg dissolve tablets to be cut in half but have not been. Wife updated. Staff report resident not wanting to wake up. P 148/90, P 83, O2 92%. Staff to monitor. R7's PN dated July 8, 2025, at 1:28 p.m., by CNS-B indicated provider faxed as wife refusing Zyprexa, Risperdal has not been used due to needing prior authorization. Note-it is unclear if resident received 2.5 mg or 5 mg as pharmacy sent 5 mg dose without cutting in half. Resident sleepy and has had several falls. Staff reeducation completed and pharmacy contacted regarding splitting pills moving forward prior to delivery. Noted new medication may be contributing factor for falls and incorrect dose and increased fatigue noted. R7's PN dated July 9, 2025, at 1:46 p.m., by CNS-B indicated vital signs follow-up as MD ordered BP 134-108 these are not correct readings. Redo with a manual.	0 620			

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0 620	Continued From page 29 R7's PN dated July 10, 2025, at 10:06 a.m., by CNS-B indicated R7 was noted to have emesis, gurgling, and shakiness, staff assisted to side with more emesis noted. BP 110/86, P 100, and rapid respirations noted. Temp 101.4. Staff instructed to send to ER for further evaluation. Wife notified and ambulance called. R7's PN dated July 11, 2025, at 11:43 a.m., by CNS-B indicated resident was sent to [name] ER on July 10, 2025, for evaluation of decreased level of consciousness, emesis, fever, weakness, and overall decline. He was admitted to [name] hospital at that time with hospice being initiated, however he passed away later that evening. R7's Discharge Care Plan dated July 11, 2025, completed by CNS-B indicated time of death July 10, 2025, at [name] hospital, cause of death was unknown. R7's record lacked documentation of any medication incident investigations, behavioral assessments, follow-ups or interventions that were provided to meet R7's needs when R7 was prescribed a new psychotropic medication and possibly administration of the incorrect dose. The licensee lacked documentation of a MAARC report indicating staff possibly gave R7 incorrect dose of Zyprexa from June 26, 2025, through July 5, 2025, lacked documentation of medication investigations and R7 expired at a hospital on July 10, 2025. On July 17, 2025, from 7:52 p.m. to 8:12 p.m., the surveyor completed an interview with RN-Q. RN-Q stated a MAARC report is filed within 24 hours. Furthermore, RN-Q stated incidents	0 620			

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0 620	Continued From page 30 would be investigated during the day by the CNS and the CNS reports to MAARC if needed. On July 18, 2025, at 11:51 a.m., the surveyor left a voicemail for CNS-B to call for an interview, however, the surveyor did not receive a call back. The licensee's Abuse Prevention policy dated March 2022, indicated all employees are advised on the Vulnerable Adult Act and their responsibilities as Mandated Reporters under state regulation. Each employee is given the information available from the state about what to watch for, what to report and their responsibilities in notifying the administrator of any concerns. In addition, it is the facility's policy to protect adults who, because of physical or mental disability or dependency, are particularly vulnerable to maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and	0 640			

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0 640	Continued From page 31 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content in common areas to include posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557 and the 911 emergency number. 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) 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: During the entrance tour on July 14, 2025, at 12:45 p.m., the surveyor did not observe the reporting number for MAARC, or 911 emergency number posted in any common areas of the assisted living. On July 16, 2025, at 11:42 a.m., consultant (C)-C confirmed the information and reporting number for MAARC, or the 911 emergency number was not posted. The licensee's Required Postings in Licensed Assisted Living Policy dated February 2022, indicated the MAARC information for reporting	0 640			

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0 640	Continued From page 32 suspected maltreatment of a vulnerable adult and 911 Emergency [sic] number in common areas near telephones would be posted in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=D	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			

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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
0 650	Continued From page 33 Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees (clinical nurse supervisor (CNS-B). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated C-C was aware of required contents in an employee record. CNS-B was hired on July 6, 2022, and provided direct care and RN supervision to residents and staff at the assisted living facility. CNS-B's employee record lacked annual performance reviews and a job description. On July 14, 2025, at 10:41 p.m., C-C emailed (electronic mail) the surveyor CNS-B records. C-C wrote in an email, "Hi there, attached is what I was able to find for [name] (CNS-B)". On July 18, 2025, at 11:51 a.m., the surveyor left a voicemail for CNS-B to call for an interview, however, the surveyor did not receive a call back. The licensee's Employee Required Documents policy dated March 22, 2022, indicated employee records included a current job description,	0 650			

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0 650	Continued From page 34 including qualifications, responsibilities, and identification of staff persons providing supervision. In addition, employee records included 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			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) 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 a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention	0 660			

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0 660	Continued From page 35 (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on May 31, 2025, and the facility was determined to be a low risk level. ULP-D was hired on May 14, 2025, to provide direct care services to residents of the facility. On July 14, 2025, at 1:00 p.m., the surveyor observed ULP-D assisting residents in the secured unit. ULP-D's employee record contained a negative Baseline TB Screening Tool for Healthcare Workers (HCWs) dated May 28, 2025. ULP-D's employee record lacked evidence of completion of a two-step TST or other evidence	0 660			

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0 660	Continued From page 36 of TB screening such as a blood test. On July 15, 2025, at 2:41 p.m., clinical nurse supervisor (CNS)-B and C-C stated ULP-D's two-step TST should have been completed on hire. CNS-B further stated [name] medical center was no longer doing the two-step TST for the licensee. CNS-B and C-C confirmed ULP-D 's two-step TST was not completed. The licensee's TB and Staff Screening policy dated June 2021, indicated new staff shall have a two-step TST conducted with results document on the Baseline TB Screening Tool for HCWs. In addition, a blood test shall be an acceptable substitute for a two-step TST. The Regulations for TB Control in Minnesota Health Care Settings dated July 2013, indicated a baseline TB screening is required for all HCWs upon hire, and included administering a two-step TST or single blood draw to screen for active TB. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680	Continued From page 37	0 680			
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 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility.	0 680			

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0 680	Continued From page 38 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: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. During the entrance tour on July 14, 2025, from 12:45 p.m. through 1:45 p.m., the surveyor did not observe signage posted in any common areas of the assisted living of where to locate the licensee's EPP. C-C verified C-C did not see the EPP signage or the written EPP plan. The licensee's electronic EPP dated June 28, 2024, signed by assisted living director in residency (ALDIR)-A, lacked the following content and/or policies and procedures to address: - an EPP available for all staff, residents, and volunteers to access; - annual review of the EPP; - a missing resident plan that was reviewed quarterly: Missing Resident policy provided was reviewed March 2024, July 2024, and July 2025, respectively; - a description of the population served by the licensee; - the medical record documentation system the facility has developed to preserve resident	0 680			

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0 680	Continued From page 39 information security and availability of records; - memorandums of agreement (MOAs) with other facilities; and - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On July 15, 2025, at 2:25 P.M., C-C stated C-C reached out to the old management company to obtain access to the computer drive. Furthermore, C-C stated C-C had emailed everything to the surveyor found that pertained to the EPP. On July 15, 2025, at 2:46 p.m., clinical nurse supervisor (CNS)-B stated she was unsure how often the missing resident policy had to be reviewed and was unsure if the licensee had completed the reviews. The licensee's Emergency Preparedness Program dated July 2025, indicated the emergency plan is developed based on facility and community-based risk assessments, using an all-hazards approach, in order to assist the facility in anticipating and addressing facility, resident, staff, volunteer, and community needs, and to support continuity of business operations prior to, during and after an emergency. The policy did not indicate how often the EPP would be reviewed. The licensee's Missing Resident policy dated July 2025, did not address how often the policy would be reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person	0 680			

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0 680	Continued From page 40 plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	0 730			

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0 730	Continued From page 41 records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included documentation of services provided for three of three residents (R1, R2, R6). This practice resulted in a level two violation (a	0 730			

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0 730	Continued From page 42 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: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. R1 R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD- difficult breathing). R1's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R1's services included medication administration, activity assistance, bathing, grooming, behavior management, dressing, safety checks, and housekeeping. R1's Service Recap Summary- Month dated July 2025, indicated the following: -July 14, and 16, respectively, indicated R1 did not have a safety check at 6:00 a.m.; -July 14, and 16, respectively, indicated R1 did not have a safety check at 7:00 a.m.; -July 14, 15, and 16, respectively, indicated R1 did not receive additional cares level 1 (one) up to 1 (one) hour weekly; -July 14, 15, and 16, respectively, indicated R1 did not receive dressing assistance in the AM	0 730			

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0 730	Continued From page 43 (morning); -July 15 indicated R1 did not receive housekeeping- Full; -July 15 indicated R1 did not receive light housekeeping; -July 14, 15, and 16, respectively, indicated R1 did not attend the AM meal; -July 14, 15, 16, and 17, respectively, indicated no bowel movements were recorded in the AM; -July 14, 15, and 16, respectively, indicated R1 did not receive transfer assistance in the AM; -July 14, 15, and 16, respectively, indicated R1 did not receive washing/grooming assistance in the AM; -July 14, 15, and 16, respectively, indicated R1 did not receive water pass in the AM; -July 15 indicated R1 did not receive a whirlpool bath; -July 14, 15, and 16, respectively, indicated R1 did not receive a safety check at 8:00 a.m.; -July 14, 15, and 16, respectively, indicated R1 did not receive behavior management at 8:30 a.m.; -July 14, 15, and 16, respectively, indicated R1 did not receive safety checks at 9:00 a.m., 10:00 a.m., 11:00 a.m., or 12:00 p.m.; -July 14, 15, 16, and 17, respectively, indicated R1 did not receive behavior management at 12:00 p.m.; -July 14, 15, and 16, respectively, indicated R1 did not attend the midday meal; -July 13 indicated R1 did not receive dressing assistance at bedtime; -July 13 indicated R1 did not receive washing/grooming at bedtime; -July 13 indicated R1 did not receive a safety check at 8:00 p.m., or 9:00 p.m.; and -July 12, 13, and 15, respectively, indicated R1 did not receive medication administration at 10:00 a.m.	0 730			

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0 730	Continued From page 44 R2 R2's diagnoses included congestive heart failure and hypertension (high blood pressure). R2's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R2's services included medication administration, activity assistance, meal attendance, escorts, oxygen management, safety checks, laundry and housekeeping. R2's Service Recap Summary - Month dated July 2025, indicated the following: -July 6, 7, and 13 respectively, indicated R2 did not receive oxygen management in AM; -July 10 indicated R2 did not receive supervision: oxygen management in AM; -July 3 indicated R2 did not receive housekeeping-full at 8:00 a.m.; -July 6, and 13 respectively, indicated R2 did not receive meal attendance in AM; -July 15 indicated R1 did not receive additional cares level 1 (one) up to 1 (one) hour weekly; -July 5, 6, 12, and 13 respectively, indicated R2 did not receive escorts at 12:00 p.m.; -July 6, and 13 respectively, indicated R2 did not receive meal attendance at 12:00 p.m.; -July 5, 6, 7, 8, 12 and 13 respectively, indicated R2 did not receive activity assistance at 2:00 p.m.; -July 1, 3, 4, 5, 6, 12, and 13 respectively, indicated R2 did not receive light housekeeping 2:00 p.m.; and July 4, 5, 6, 7, 12, and 13 respectively, indicated R2 did not receive a safety check at 2:00 p.m. R6 R6's diagnosis included hypertension and anxiety	0 730			

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0 730	Continued From page 45 disorder. R6's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R2's services included medication administration, compression stockings, dressing assistance, meal attendance, safety checks, laundry and housekeeping. R6's Service Recap Summary - Month dated July 2025, indicated the following: -July 5, 6, 12, and 13 respectively, indicated R6 did not receive light housekeeping at 2:00 p.m.; -July 6, and 13, respectively, indicated R6 did not receive compression stocking assistance at 8:00 a.m.; -July 6, and 13, respectively, indicated R6 did not receive meal attendance in 8:00 a.m.; -July 5, 6, 12, and 13, respectively, indicated R6 did not receive meal attendance in 12:00 p.m.; - and -July 10 indicated R6 did not receive supervision: compression stockings at 7:00 p.m. R1, R2, R6's records lacked documentation of the services noted above, or the reason why the service was not provided to R1, R2 and R6 On July 15, 2025, from 9:00 a.m. through 9:30 a.m., the surveyor interviewed R5 (R6's spouse) whom stated R6 was paying for dressing and compression stocking assistance, however, R5 states R5 will assist R6 as staff do not come to assist with dressing and the compression stockings. On July 15, 2025, at 2:50 p.m., clinical nurse supervisor (CNS)-B stated most likely resident tasks were not documented because staff forgot	0 730			

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0 730	Continued From page 46 to document. Furthermore, CNS-B stated CNS-B has reeducated staff in the past on the importance of documenting services. On July 18, 2025, at 11:31 a.m., registered nurse (RN)-Q stated CNS-B should have been following up on R1's services to ensure R1 was receiving all services listed on R1's service plan. RN-Q further stated RN-Q thought all of R1's services had been provided, however, RN-Q was an on-call nurse for the facility and was not required to be onsite. RN-Q stated RN-Q had no concerns about R1's services being neglected and staff most likely forgot to document R1's services. The licensee's Service Plan policy dated March 30, 2021, indicated [facility name] will implement and provide all services required by the current service plan, with the exception of the resident refusing the services or if the resident is not in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA GREENLEAF		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701			
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0 775	Continued From page 47 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 the potential to affect a large portion or all of the residents). Findings include: On a facility tour on July 15, 2025, at 10:35 a.m., with assisted director (AD)-E and consultant (C), the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a delayed egress locking system installed on all exit doors, in the memory care, leading to the exterior exit path. The delayed egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location in order for occupants to exit in the event of an emergency. The delayed egress locking system is required to be provided with a switch or device located at the nurse station or other approved location to deactivate the delayed egress locked exit doors in order for building occupants to exit in the event of an emergency. During an interview at 10:45 a.m., AD-E, stated the procedures required to operate and unlock	0 775			

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0 775	Continued From page 48 the delayed egress door locking system were not included in the fire safety and evacuation plan. The procedures required to operate and unlock the delayed egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. FIRE-RESISTANT RATED DOORS During the facility tour with AD-E. Surveyor observed several of the resident fire-rated doors throughout the facility were propped open with rubber door wedges as well as the laundry room doors. Fire rated doors in the corridor leading from the library to the towers were propped open with the kick down door holder. 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 MNSFC Section 1105. Carbon Monoxide Detectors: There were carbon monoxide alarms with a local alarm only provided by some of the maintenance doors and in most of the residents sleeping rooms but there were no carbon monoxide alarms observed within 10 feet of the sleeping rooms. Carbon monoxide detection systems with carbon monoxide detectors installed at the location of the source of carbon monoxide or between the source and the sleeping units are required to be	0 775			

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0 775	Continued From page 49 provided with sounding devices at the nurse station or other approved constantly attended location. The surveyor observed there was carbon monoxide detectors throughout the facility and in most of the resident sleeping rooms. These carbon monoxide detectors were not interconnected with the fire alarm system. Carbon monoxide detection systems with carbon monoxide detectors installed at the location of the source of carbon monoxide are required to be provided with sounding devices at the nurse station or other approved constantly attended location. Carbon monoxide alarms or detection systems are required and shall be installed in accordance with MSFC in Minnesota Rules Chapter 7511 and the local fire and building code enforcement official. Carbon monoxide protection shall be provided in the building to meet the Minnesota State Fire Code. C-C verified the above listed observations while accompanying on the tour. Smoking: On facility tour with AD-E it was observed that cigarette butts were being dispensed into a metal cigarette butt receptacle that was attached to the building's vinyl siding. AD-E was unable to provide any information from the manufacture on is this was an approved receptacle and mounted correctly. There appeared to be burns in the vinyl siding above this receptacle.	0 775			

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0 775	Continued From page 50 The surveyor explained to AD-E, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place outside in the designated area away from the structure. The deficient condition was visually verified by AD-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 800			

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0 800	Continued From page 51 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 July 15, 2025, at 10:45 a.m., surveyor toured the facility with assistant director (AD)-E. The following was observed: GENERAL MAINTENANCE: Carpet was coming up throughout the facility in the activity and dining room areas and memory care, library and tower hallways. Resident room #2011 had tools, clothes, garbage and various other personal items which were blocking the points of egress. This room had heavily soiled carpet throughout his bedroom and living quarters. Resident room # 3002 had the smoke alarm coming off the ceiling. The smoke alarm still functioned. The emergency exit sign going into the memory care had the light falling off. AD-E stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			

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0 810	Continued From page 52	0 810			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810			

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0 810	Continued From page 53 Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and 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). The findings include: On July 15, 2025, at 10:50 a.m. assistant director (AD)-E was unable to provide documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. AD-E stated that she understood the requirements of maintaining this plan. TRAINING: The licensee failed to provide evacuation training to staff and residents as required. AD-E stated that she understood the requirements for training the employees and residents. DRILLS: The licensee failed to conduct evacuation drills for employees as required.	0 810			

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0 810	Continued From page 54 AD-E stated that she understood the requirements for employees conducting evacuation drills twice per year per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract.	0 900			

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0 900	Continued From page 55 Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. 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 the required content for one of two 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) 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: R1 was admitted to the assisted living facility with dementia care on June 6, 2023. R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD- difficult breathing). R1's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R1's services included medication administration, activity assistance, bathing, grooming, behavior management, dressing, safety checks, and housekeeping. R1's record lacked evidence the contract had been fully executed as the facility must: - give a complete copy of any signed contract and	0 900			

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0 900	Continued From page 56 any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On July 18, 2025, at 11:16 a.m., registered nurse (RN)-Q stated RN-Q was not sure who went through the contracts with residents, however, RN-Q had though it was administration. RN-Q further stated RN-Q thought residents had a to sign a contract upon admission. RN-Q stated the administration staff was out of office due to medical reasons and would not be available for interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290			

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01290	Continued From page 57 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: This correction order was modified on August 15, 2025, to reflect additional information provided by the licensee. The order was changed and the licensee's Employee Required Documents policy was added. Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for seven of 51 employees (unlicensed personnel (ULP)-F, ULP-G, ULP-H, ULP-I, dietary (D)-J, D-K, D-L). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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: This resulted in an immediate correction order on July 16, 2025. During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated C-C was aware of required contents in an employee record.	01290			

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01290	Continued From page 58 NO BACKGROUND STUDY ULP-F ULP-F was hired on August 30, 2024, to provide direct care services to residents at the facility. ULP-F's payroll hours printed July 15, 2025, indicated from July 1, 2025, through July 14, 2025, ULP-F worked 146.91 hours. ULP-G ULP-G was hired on November 10, 2024, to provide direct care services to residents at the facility. ULP-G's payroll hours printed July 15, 2025, indicated from November 24, 2025, through July 14, 2025, ULP-F worked 1012.95 hours. ULP-H ULP-H was hired on December 19, 2024, to provide direct care services to residents at the facility. ULP-H's payroll hours printed July 15, 2025, indicated from February 26, 2025, through July 14, 2025, ULP-F worked 607.45 hours. ULP-I ULP-I was hired on April 8, 2025, to provide direct care services to residents at the facility. ULP-I's payroll hours printed July 15, 2025, indicated from April 24, 2025, through July 14, 2025, ULP-F worked 324.71 hours. D-J D-J was hired on June 2, 2025, to provide direct care services to residents at the facility.	01290			

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01290	Continued From page 59 D-J's payroll hours printed July 15, 2025, indicated from June 5, 2025, through July 5, 2025, D-J worked 189.10 hours. D-K D-K was hired on June 4, 2025, to provide direct care services to residents at the facility. D-K's payroll hours printed July 15, 2025, indicated from June 24, 2025, through July 4, 2025, D-K worked 221.09 hours. D-L D-L was hired on June 5, 2025, to provide direct care services to residents at the facility. D-L's payroll hours printed July 15, 2025, indicated from June 9, 2025, through July 15, 2025, D-L worked 284.94 hours. ULP-F, ULP-G, ULP-H, ULP-I, D-J, D-K, D-L's employee record lacked a current cleared background study. On July 15, 2025, at 2:15 p.m., the surveyor reviewed the licensee's NETStudy 2.0 roster with consultant (C)-C and assistant director (AD)-E. AD-E stated the above were current employees for the licensee and had worked without direct supervision. Additionally, C-C and AD-E stated a cleared background study should have been completed prior to employees working independently and was unsure why the studies were not completed. The licensee's Employee Required Documents policy dated March 22, 2022, indicated items listed below are in compliance with 144G.42. Subd. 8. The facility must maintain current records of each paid employee, each regularly	01290			

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01290	Continued From page 60 scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: Documentation of Minnesota (MN) required Background study as required under section 144.057. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			

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01440	Continued From page 61	01440			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one unlicensed personnel (ULP)-D. 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	01440			

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01440	Continued From page 62 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on May 14, 2025, to provide direct care services to residents of the facility. ULP-D's employee record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On July 14, 2025, at 1:00 p.m., the surveyor observed ULP-D assisting residents in the secured unit. On July 15, 2025, at 2:39 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was unable to locate ULP-D's 30-day supervision review and was not sure why it was not completed. A policy was requested, however was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified	01540			

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01540	Continued From page 63 under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D) received the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01540			

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01540	Continued From page 64 The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license issued on November 1, 2024, through October 31, 2025. During the entrance conference on July 14, 2025, at 12:00 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. CNS-B CNS-B was hired on July 6, 2022, and provided direct care and RN on call services for residents and supervision of staff at the facility. ULP-D ULP-D was hired on May 14, 2025, to provide direct care services to residents at the facility. On July 14, 2025, at 1:00 p.m., the surveyor observed ULP-D assisting residents in the secured unit. CNS-B and ULP-D's employee record lacked evidence CNS-B and ULP-D had completed two (2) hours of mental illness and de-escalation training by July 1, 2025. On July 18, 2025, at 11:51 a.m., the surveyor left a voicemail for CNS-B to call for an interview, however, the surveyor did not receive a call back. On July 18, 2025, at 11:55 a.m., registered nurse (RN)-Q stated CNS-B completes the education with the staff, so RN-Q was unsure about who would assign the training. No further information was provided.	01540			

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01540	Continued From page 65	01540			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01620 SS=H	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620			

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01620	Continued From page 66 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident 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 registered nurse (RN) failed to conduct a comprehensive reassessment for two of two residents (R1, R7). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: This resulted in an immediate correction order on July 18, 2025. During the entrance conference on July 14, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated CNS-B completed preadmission, 14-day, 90 day, and change of condition assessments, including falls, when CNS-B is onsite during the	01620			

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01620	Continued From page 67 day. CNS-B further stated RN-Q was the on-call nurse, took call after hours, and completed the assessments for falls or the assessment is done the next business day, and if there is any injury staff are not to move the resident and call a nurse. R1 R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD - difficult breathing). R1's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R1's services included medication administration, activity assistance, bathing, grooming, behavior management, dressing, safety checks, and housekeeping. R1's Individual Abuse Prevention Plan dated July 11, 2025, indicated facility will manage all medications, staff to administer all medications, and ensure R1 takes ordered medications. R1's Hospital Nurse Note dated July 9, 2025, at 9:42 p.m., written by RN-Q indicated R1 was admitted to the hospital with a urinary tract infection (UTI) and kidney infection. R1's Return Nurse Note dated July 11, 2025, at 12:04 p.m., written by CNS-B indicated R1 returned from the hospital and new medication included Cipro 250 milligrams (mg) by mouth twice daily for UTI. R1's prescriber orders dated July 11, 2025, included an order for Ciprofloxacin (Cipro) 250 mg by mouth twice daily for six days. R1's Phone Nurse Note dated July 16, 2025 (5 days after Cipro was supposed to be administered), at 4:07 p.m., written by CNS-B indicated phone message to provider/hospital regarding Cipro order from hospital return-pharmacy did not receive order- need further instruction regarding this (Cipro order).	01620			

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01620	Continued From page 68 R1's Admission Assessment dated July 11, 2025, completed by CNS-B indicated the facility nurse will verify that all medications are administered as prescribed and monitor of [sic] medication use to prevent possible complications of adverse reactions by competency training and supervising appropriate staff to administer medications. In addition, R1 denied any active genitourinary (GU-kidney and bladder) problems. R1's Med (medication) Admin (administration) Summary- Actual- Month dated July 2025, indicated the following: -July 12, 13, 14, 15, 16, and 17, respectively, R1 did not receive Cipro 250 mg dose scheduled at 8:00 a.m.; and -July 11, 12, 13, 14, 15, and 16, respectively, R1 did not receive Cipro 250 mg dose scheduled at 8:00 p.m. R1's Service Recap Summary- Month dated July 2025, indicated the following: -July 14, and 16, respectively, indicated R1 did not have a safety check at 6:00 a.m.; -July 14, and 16, respectively, indicated R1 did not have a safety check at 7:00 a.m.; -July 14, 15, and 16, respectively, indicated R1 did not receive additional cares level 1 (one) up to 1 (one) hour weekly; -July 14, 15, and 16, respectively, indicated R1 did not receive dressing assistance in the AM (morning); -July 15 indicated R1 did not receive housekeeping- Full; -July 15 indicated R1 did not receive light housekeeping; -July 14, 15, and 16, respectively, indicated R1 did not attend the AM meal; -July 14, 15, 16, and 17, respectively, indicated no bowel movements were recorded in the AM; -July 14, 15, and 16, respectively, indicated R1 did not receive transfer assistance in the AM;	01620			

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01620	Continued From page 69 -July 14, 15, and 16, respectively, indicated R1 did not receive washing/grooming assistance in the AM; -July 14, 15, and 16, respectively, indicated R1 did not receive water pass in the AM; -July 15 indicated R1 did not receive a whirlpool bath; -July 14, 15, and 16, respectively, indicated R1 did not receive a safety check at 8:00 a.m.; -July 14, 15, and 16, respectively, indicated R1 did not receive behavior management at 8:30 a.m.; -July 14, 15, and 16, respectively, indicated R1 did not receive safety checks at 9:00 a.m., 10:00 a.m., 11:00 a.m., or 12:00 p.m.; -July 14, 15, 16, and 17, respectively, indicated R1 did not receive behavior management at 12:00 p.m.; -July 14, 15, and 16, respectively, indicated R1 did not attend the midday meal; -July 13 indicated R1 did not receive dressing assistance at bedtime; -July 13 indicated R1 did not receive washing/grooming at bedtime; -July 13 indicated R1 did not receive a safety check at 8:00 p.m., or 9:00 p.m.; -July 12, 13, and 15, respectively, indicated R1 did not receive medication administration at 10:00 a.m.; and -July 16 indicated R1 continued to decrease in memory over the weeks, asking what to do, falls, confusion, asking about bus rides, getting upset when she (R1) can't remember something, staying in bed more frequently then she (R1) would 3-4 months ago, should be seen. R1's record lacked a change of condition assessment and implementation of monitoring interventions after R1 returned to the facility on July 11, 2025, and had not received any dose of Cipro 250 mg.	01620			

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01620	Continued From page 70 On July 17, 2025, at 4:22 p.m., the surveyor left a voicemail for CNS-B to call for an interview, however, the surveyor did not receive a call back. On July 17, 2025, from 4:29 p.m. through 4:38 p.m., the surveyor completed an interview with RN-Q. RN-Q stated RN-Q was informed by CNS-B yesterday (July 16, 2025) that R1's Cipro had not arrived at the facility. RN-Q stated CNS-B had tried to call R1's provider multiple times, however, R1's provider had not returned any calls to CNS-B. RN-Q further stated the only note in R1's record regarding contacting R1's provider was July 16, 2025 (five days after Cipro 250 mg was supposed to be administered), at 4:07 p.m. RN-Q stated usually the pharmacy delivered resident's antibiotics right away, ULPs were supposed to notify nursing staff if the antibiotic had not shown up, however, no notification had been made by ULPs to nursing staff. RN-Q further stated RN-Q typically did not go to the facility if a resident needed an assessment, however, RN-Q would contact the resident's family to see if the resident could go to the emergency room to be assessed, otherwise ULPs would just monitor the resident on a case-by-case basis. RN-Q stated to ensure R1 did not get urosepsis (life-threatening complication of an infection of the urinary system), ULPs would contact RN-Q if R1 reported pain or R1 was not up and walking, nor had the facility instructed ULPs on what specifically to monitor for regarding signs and symptoms of urosepsis. RN-Q stated RN-Q was going to call the facility to check on R1, to see if R1's family wanted R1 to go to the emergency room for antibiotics, or make an appointment for R1 tomorrow (July 18, 2025) to see about R1 receiving Cipro 250 mg. On July 17, 2025, from 7:52 p.m., through 8:12 p.m., the surveyor completed an interview with	01620			

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01620	Continued From page 71 RN-Q. RN-Q stated she had spoken with CNS-B and CNS-B stated she had not heard back from the provider. RN-Q stated she had spoken with staff following above interview and staff reported R1 was walking out and was good. RN-Q further stated RN-Q had spoken with R1's niece to inform her the medication had not come in and the niece informed RN-Q she had an appointment with her provider tomorrow (July 18, 2025). On July 18, 2025, from 8:11 a.m. through 8:18 a.m., the surveyor received a return call from CNS-B for interview. CNS-B stated CNS-B did not realize R1's Cipro hadn't arrived from the pharmacy since R1 returned from the hospital on a Friday and CNS-B does not work on the weekend. CNS-B further stated usually the ULPs will contact the pharmacy for any medication that had not arrived at the facility or contact the nurse on call, however, for "some reason" that (ULPs did not contact the pharmacy or nurse on call) did not happen and it is an "unfortunate" situation. CNS-B stated CNS-B reached out to the provider via telephone and fax on or around July 15, 2025, or July 16, 2025, however, CNS-B would have to pull fax records to know for sure what date CNS-B called and faxed the provider. CNS-B stated when CNS-B completed R1's assessment on July 11, 2025, at 12:03 p.m., CNS-B must have forgot to check the box under genitourinary to include R1 was diagnosed with a bladder infection and kidney infection. CNS-B further stated the facility relies heavily on ULPs to report any changes in resident condition, however, CNS-B stated CNS-B did not put any interventions in place to address ULPs monitoring R1 for urosepsis, such as checking vital signs or R1's temperature. CNS-B stated no additional assessments were assigned to R1 to assess for a change of condition since the RNs relied on the	01620			

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01620	Continued From page 72 ULPs to report any change of condition for R1. CNS-B further stated the RN on call over the night and weekends was required to come onsite to the facility to complete a change of condition assessments on residents as needed. R7 R7's diagnosis included Alzheimer's dementia, agitation, and falls. R7's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R7's services included medication administration, activity assistance, bathing, grooming, incontinence management, dressing, compression stockings, safety checks, meal assistance (including feeding), laundry, and housekeeping. R7's preadmission assessment dated April 22, 2025, completed by CNS-B indicated R7 had one fall in the past month, no emergency room (ER) visits or hospitalizations in the past 3 months. The assessment further indicated R7 was independent with ambulation, bed mobility and transfers, however, was unsteady. Falls interventions included, proper footwear, no clutter in room, no throw rugs, assist as needed, and a night light at night. R7's preadmission assessment dated May 1, 2025, completed by CNS-B indicated R7 was independent with ambulation, bed mobility and transfers, however, was unsteady. Falls interventions included, proper footwear, no clutter in room, no throw rugs, assist as needed, and a night light at night. R7's progress note (PN) dated May 1, 2025, at 8:45 p.m., by RN-Q, indicated staff called to report resident had a fall in the living room area witnessed by staff in the evening. He had gotten up from sitting and fell. No injury or pain reported. Assisted up. R7 had a temperature (T)	01620			

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NAME OF PROVIDER OR SUPPLIER MINNESOTA GREENLEAF		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701			
(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 73 99.3, blood pressure (BP) 140/90, pulse (P) 89, respirations (R) 17, and oxygen saturation (O2) 99%. T taken in bed after relaxed and read 98.4. Family reported to staff in the afternoon that is resident does get nap get his afternoon nap around noon he becomes weak and falls (sic). Staff called family. R7's PN dated May 2, 2025, at 9.37 a.m., by CNS-B indicated prescriber faxed regarding fall from May 1, 2025, and inquired about physical/occupational therapy (PT/OT) evaluation. Family feels walker would make him more at risk for falls, wonder about wheelchair. High fall risk due to unsteadiness. Fall precautions in place. Family aware of situation. R7's PN dated May 3, 2025, at 10:00 p.m., by RN-Q indicated resident was found on the floor in his room, he was incontinent of BM (bowel movement). Asked if he had to go to the bathroom and he said yes. No injury noted, Staff assisted up and cleaned up. Staff called family, did not want to go to ER, monitor him. If any concern notify nurse. R7's PN dated May 4, 2025, at 9:21 p.m., by RN-Q indicated resident had a fall at 6:30 p.m. in the living room. He got up and became weak, staff witnessed fall. Staff ended up falling with him while trying to help him from falling. No injury noted. Vitals-BP 156/94, T 98.3, R 80. Family was called and family asked if he had a nap. He did have a two-hour nap. Resident then had a second fall around 8:00 p.m., stood up in living room and had a fall. He became weak and fell. Family called. Vitals not taken as resident would not allow staff to do so. Nurse feels he should have PT evaluation or perhaps walker for safety. R7's PN dated May 5, 2025, at 9:21 p.m., by CNS-B indicated provider updated on falls, and falls precautions in place. R7's assessment dated May 15, 2025, completed	01620			

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01620	Continued From page 74 by RN-Q indicated R7 had six falls in the past three months. The assessment further indicated R7 was independent, and no assistance needed with ambulation, bed mobility and transfers, however, was unsteady. Falls interventions: proper footwear, no clutter in room, no throw rugs, assist as needed, night light at night. Actions taken to address falls: proper footwear, no clutter in room, no throw rugs, assist as needed, night light at night. R7's PN dated May 28, 2025, at 10:45 p.m., by RN-Q indicated resident had fall in bedroom, R7 was assisted to bed and 15 minutes later got out of bed and fell. Complained of hip pain. Nurse instructed to not move R7, suggested ER, family agreed. R7's PN dated May 28, 2025, at 11:06 a.m., by RN-Q indicated ER had called to report R7 had a computed tomography (CT) scan for fall and abscess found. Sending clindamycin antibiotic to pharmacy. R7's PN dated May 29, 2025, at 4:35 p.m., by CNS-B indicated provider updated on falls. R7's PN dated June 3, 2025, at 8:33 p.m., by RN-Q indicated provider ordered crushed Tylenol and give at bedtime, extended antibiotic for dental another four days. Will consider dental extraction if suffering from dental pain. R7's PN dated June 9, 2025, at 11:00 a.m., by LPN-R indicated wheelchair fitting tomorrow. R7's PN dated June 10, 2025, at 8:58 a.m., by RN-Q indicated staff called to report fall at 6:30 a.m. to report staff had been completing resident rounds and after leaving room staff heard R7 fall. Found laying on his back. No pain or injury. Family refused ER, staff to monitor. R7's PN dated June 10, 2025, at 12:19 p.m., by CNS-B indicated OT eval for wheelchair. R7's PN dated June 22, 2025, at 1:54 p.m., by ULP-D indicated R7 aggressive, hitting and	01620			

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01620	Continued From page 75 swearing. R7's PN dated June 23, 2025, at 2:47 p.m., by CNS-B indicated provider faxed requesting prior authorization for as needed risperidone. R7's PN dated June 25, 2025, at 11:04 a.m., by CNS-B indicated provider ordered Zyprexa 2.5 milligram twice daily for aggressive behavior and collect urine. R7's PN dated June 26, 2025, at 8:34 a.m., by RN-Q indicated staff reported fall, no injury indicated. R7's PN dated June 26, 2025, at 10:03 p.m., by RN-Q indicated urine obtained. R7's June 2025 electronic medication administration summary indicated on June 25, 2025, R7 started on Zyprexa dissolving tablet, Take 2.5 milligram by mouth daily for aggressive behavior. Take half of 5 mg tablet. Medication was administered: -8:00 a.m. dose: June 26, 27, 28, 29, 30, July 5, 6 [dose indicated as refused, wife refused, or sleeping for July 1-4 and July 7-8] -8:00 p.m. dose: June 26, 27, 28, 29, 30, July 5 [dose indicated as refused, wife refused, or sleeping for July 1-4, and July 6-7] R7's PN dated June 28, 2025, at 8:58 a.m., by RN-Q indicated fall in room at 3:20 a.m., denied injury. R7's PN dated June 28, 2025, at 9:46 p.m., by RN-Q indicated second fall, hit his head and had bump on forehead. Staff felt R7 not acting correct. Sent to ER, scans clear, urine clear. No changes. Use ice and acetaminophen as needed. R7's PN dated June 29, 2025, at 1:11 p.m., by RN-Q indicated resident found on floor this a.m., by bed around 6:30 a.m., first BP slightly elevated, rechecked and was 144/89. Wife refused ER and monitor. R7's PN dated July 5, 2025, at 8:11 a.m., by RN-Q indicated staff reported R7 fell on July 3,	01620			

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01620	Continued From page 76 2025, in the evening and yesterday July 4, 2025. Resident had three falls throughout the day. No injuries, no skin issues, no changes in cognitive changes. Wife notified; wife refused ER. R7's PN dated July 7, 2025, at 7:21 p.m., by RN-Q indicated residents wife feels medication to much and "snowing" (causing sedation, unresponsiveness) R7. Wife refusing medication for R7. Staff noted medication Zyprexa 5 mg dissolve tablets to be cut in half but have not been. Wife updated. Staff report resident not wanting to wake up. P 148/90, P 83, 02 92%. Staff to monitor. R7's PN dated July 8, 2025, at 1:28 p.m., by CNS-B indicated provider faxed as wife refusing Zyprexa, Risperdal has not been used due to needing prior authorization. Note-it is unclear if resident received 2.5 mg or 5 mg as pharmacy sent 5 mg dose without cutting in half. Resident sleepy and has had several falls. Staff reeducation completed and pharmacy contacted regarding splitting pills moving forward prior to delivery. Noted new medication may be contributing factor for falls and incorrect dose and increased fatigue noted. R7's PN dated July 9, 2025, at 1:46 p.m., by CNS-B indicated vital signs follow-up as MD ordered BP 134-108 these are not correct readings. Redo with a manual. R7's PN dated July 10, 2025, at 10:06 a.m., by CNS-B indicated R7 was noted to have emesis, gurgling, and shakiness, staff assisted to side with more emesis noted. BP 110/86, P 100, and rapid respirations noted. Temp 101.4. Staff instructed to send to ER for further evaluation. Wife notified and ambulance called. R7's PN dated July 11, 2025, at 11:43 a.m., by CNS-B indicated resident was sent to [name] ER on July 10, 2025, for evaluation of decreased level of consciousness, emesis, fever, weakness,	01620			

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01620	Continued From page 77 and overall decline. He was admitted to [name] hospital at that time with hospice being initiated, however he passed away later that evening. R7's Discharge Care Plan dated July 11, 2025, completed by CNS-B indicated time of death July 10, 2025, at [name] hospital, cause of death was unknown. R7's 2025 fall incident reports dated: May 3, 4, 10, 28; June 26, 27, 28; and July 3, 4, 5 did not include a comprehensive assessment or new interventions. R7's May, June, and July 2025, service recap summary did not include ambulation or transfer assistance. The licensee failed to complete a change of condition following above falls, tooth infection and change in medications, including failure to implement new fall prevention interventions with each fall. On July 17, 2025, from 7:52 p.m. to 8:12 p.m., the surveyor completed an interview with RN-Q. RN-Q stated the process following a witnessed fall with no injury would be the staff would complete vitals and call the nurse, fill out an incident report and the nurse would perform a fall follow-up within 24 hours, which would consist of a nursing assessment. RN-Q stated RN-Q does not do the follow up assessments, usually CNS-B completes the assessments during the day. RN-Q stated if a resident falls with injury they are sent into the ER for evaluation and upon return a complete assessment should be completed. RN-Q stated RN-Q goes onsite into the facility if needed. RN-Q stated R7 should have had assessments completed following the falls and ER returns. RN-Q stated she was unsure of the policy for placing new interventions, however, new interventions should be put in place when needed. The manufacturer ' s instructions for Zyprexa	01620			

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01620	Continued From page 78 dated 2009, indicated elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Zyprexa is not approved for the treatment of patients with dementia-related psychosis (lost touch of reality). Zyprexa may cause serious side effects, including increased risk of death, have memory loss, and have lost touch with reality. Common side effects of Zyprexa included sleepiness and tremor (shakes). The licensee's Service Plan, Assessments and Monitoring policy revised on April 2023, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the resident and cannot exceed 90-days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individuals needs. When a facility resident aide, med (medication) aide, licensed practical nurse (LPN) or RN staff member note a potential additional need and/or service for a resident, they will either complete a service change form or notify an RN of their observation. The notification and/or "Provider Communication" form will be reviewed and evaluated by a RN. If it is noted that the information reported by the staff member may result in a change of condition or the resident or a newly noted service need, the nurse will complete an assessment of the resident. Upon completion of the assessment, the service plan will be adjusted accordingly as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

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01640	Continued From page 79 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the facility to document agreement on the services to be provided for three of three residents (R1, R2, R6). 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	01640			

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01640	Continued From page 80 affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. Additionally, clinical nurse supervisor (CNS)-B stated CNS-B and registered nurse (RN)-Q develop, maintain and update the service plans as needed. R1 R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD- difficult breathing). R1's Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. R2 R2's diagnoses included congestive heart failure and hypertension (high blood pressure). R2's Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. R6 R6's diagnosis included hypertension and anxiety disorder.	01640			

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01640	Continued From page 81 R6's Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On July 18, 2025, at 11:13 a.m., RN-Q stated the licensee had a resident or resident's representative sign a service plan annually or every 90 days if a change was made to the resident's services. RN-Q further stated CNS-B was responsible for obtaining the resident signature along with the licensee's representative signature and was unsure why R1's service plan was not signed. On July 18, 2025, at 12:08 p.m., RN-Q stated service plans should be signed on admission, annually or if there was a change in services provided to a resident. RN-Q stated CNS-B completes these during the day and was unsure why service plans were not signed. The licensee's Service Plan, Assessments and Monitoring policy dated April 2023, indicated the service plan and any revisions must include a signature or other authentication by facility Nurse [sic] or Administration [sic] and by the resident or the resident's representative documenting agreements on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01730	Continued From page 82	01730			
01730 SS=G	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 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	01730			

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01730	Continued From page 83 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: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of two residents (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: This resulted in an immediate correction order on July 18, 2025. During the entrance conference on July 14, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD- difficult breathing).	01730			

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01730	Continued From page 84 R1's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R1's services included medication administration, activity assistance, bathing, grooming, behavior management, dressing, safety checks, and housekeeping. R1's Individual Abuse Prevention Plan dated July 11, 2025, indicated facility will manage all medications, staff to administer all medications, and ensure R1 takes ordered medications. R1's Hospital Nurse Note dated July 9, 2025, at 9:42 p.m., written by registered nurse (RN)-Q indicated R1 was admitted to the hospital with a diagnosis of a urinary tract infection (UTI) and kidney infection. R1's Return Nurse Note dated July 11, 2025, at 12:04 p.m., written by CNS-B indicated R1 returned from the hospital and new medication included Cipro (antibiotic to treat infection) 250 milligrams (mg) by mouth twice daily for UTI. R1's Admission Assessment dated July 11, 2025, completed by CNS-B indicated the facility nurse will verify that all medications are administered as prescribed and monitor of [sic] medication use to prevent possible complications of adverse reactions by competency training and supervising appropriate staff to administer medications. In addition, R1 denied any active genitourinary (GU- kidney and bladder) problems. R1's prescriber orders dated July 11, 2025, included an order for Ciprofloxacin (Cipro) 250 mg by mouth twice daily for six days. R1's Med (medication) Admin (administration)	01730			

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NAME OF PROVIDER OR SUPPLIER MINNESOTA GREENLEAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701		
(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
01730	Continued From page 85 Summary- Actual- Month dated July 2025, indicated the following: -July 12, 13, 14, 15, 16, and 17, respectively, R1 did not receive Cipro 250 mg dose scheduled at 8:00 a.m.; and -July 11, 12, 13, 14, 15, and 16, respectively, R1 did not receive Cipro 250 mg dose scheduled at 8:00 p.m. Unlicensed personnel (ULPs) documented the above noted medications as not administered to R1's Cipro not in, not on cart, not in stock, or not on cart DON (director of nursing/CNS) notified. R1's Phone Nurse Note dated July 16, 2025 (five days after Cipro was supposed to be administered), at 4:07 p.m., written by CNS-B indicated phone message to provider/hospital regarding Cipro order from hospital return-pharmacy did not receive order- need further instruction regarding this (Cipro order). R1's record lacked documentation of any follow-up procedures or interventions that were provided to meet R1's needs when R1's Cipro 250 mg was not available to be given to R1. In addition, R1's record lacked documentation, which notified R1's physician or family of prescribed Cipro 250 mg not administered to R1 from July 11, 2025, through July 16, 2025, at 4:07 p.m. On July 17, 2025, at 4:22 p.m., the surveyor left a voicemail for CNS-B to call for an interview, however, the surveyor did not receive a call back. On July 17, 2025, from 4:29 p.m. through 4:38 p.m., the surveyor completed an interview with RN-Q. RN-Q stated RN-Q was informed by CNS-B yesterday (July 16, 2025) that R1's Cipro	01730			

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01730	Continued From page 86 had not arrived at the facility. RN-Q stated CNS-B had tried to call R1's provider multiple times, however, R1's provider had not returned any calls to CNS-B. RN-Q further stated the only note in R1's record regarding contacting R1's provider was July 16, 2025 (five days after Cipro 250 mg was supposed to be administered), at 4:07 p.m. RN-Q stated usually the pharmacy delivered resident's antibiotics right away, ULPs were supposed to notify nursing staff if the antibiotic had not shown up, however, no notification had been made by ULPs to nursing staff. RN-Q further stated RN-Q typically did not go to the facility if a resident needed an assessment, however, RN-Q would contact the resident's family to see if the resident could go to the emergency room to be assessed, otherwise ULPs would just monitor the resident on a case-by-case basis. RN-Q stated to ensure R1 did not get urosepsis (life-threatening complication of an infection of the urinary system), ULPs would contact RN-Q if R1 reported pain or R1 was not up and walking, nor had the facility instructed ULPs on what specifically to monitor for regarding signs and symptoms of urosepsis. RN-Q stated RN-Q was going to call the facility to check on R1, to see if R1's family wanted R1 to go to the emergency room for antibiotics, or make an appointment for R1 tomorrow (July 18, 2025) to see about R1 receiving Cipro 250 mg. On July 18, 2025, from 8:11 a.m. through 8:18 a.m., the surveyor received a return call from CNS-B for interview. CNS-B stated CNS-B did not realize R1's Cipro hadn't arrived from the pharmacy since R1 returned from the hospital on a Friday and CNS-B does not work on the weekend. CNS-B further stated usually the ULPs will contact the pharmacy for any medication that	01730			

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01730	Continued From page 87 had not arrived at the facility or contact the nurse on call, however, for "some reason" that (ULPs did not contact the pharmacy or nurse on call) did not happen and it is an "unfortunate" situation. CNS-B stated CNS-B reached out to the provider via telephone and fax on or around July 15, 2025, or July 16, 2025, however, CNS-B would have to pull fax records to know for sure what date CNS-B called and faxed the provider. CNS-B stated when CNS-B completed R1's assessment on July 11, 2025, at 12:03 p.m., CNS-B must have forgot to check the box under genitourinary to include R1 was diagnosed with a bladder infection and kidney infection. CNS-B further stated the facility relies heavily on ULPs to report any changes in resident condition, however, CNS-B stated CNS-B did not put any interventions in place to address ULPs monitoring R1 for urosepsis, such as checking vital signs or R1's temperature. CNS-B stated no additional assessments were assigned to R1 to assess for a change of condition since the RNs relied on the ULPs to report any change of condition for R1. CNS-B further stated the RN on call over the night and weekends was required to come onsite to the facility to complete a change of condition assessments on residents as needed. The licensee's Medication and Treatment Orders Implementation policy dated August 26, 2020, indicated the change in medications will be initiated within 24 hours. The policy further indicated this action (medication change) will be pending the receipt of the medication onsite at the facility within this outlined timeline. The licensee's Medication Management Service-Med (medication) Aide policy dated August 26, 2020, indicated medication management services provided by a med (medication) aide will be	01730			

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01730	Continued From page 88 performed consistent with North Dakota Comprehensive Home Care Rules and North Dakota Department of Health. The policy further indicated the facility will prepare and include in the Service Plan a written statement of the medication management services that will be provided to the client. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered per prescriber orders for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760			

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01760	Continued From page 89 safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on July 14, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD- difficult breathing). R1's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R1's services included medication administration. R1's Individual Abuse Prevention Plan dated July 11, 2025, indicated facility will manage all medications, staff to administer all medications, and ensure R1 takes ordered medications. R1's prescriber orders dated July 11, 2025, included an order for meclizine (for dizziness) 12.5 milligrams (mg) every four hours as needed. R1's Med (medication) Admin (administration)- Actual- Month dated July 2025, indicated meclizine give up to three times a day. R1's electronic medication administration record (EMAR) lacked the correct transcription for meclizine with all required content.	01760			

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01760	Continued From page 90 On July 18, 2025, at 11:20 a.m., registered nurse (RN)-Q stated RN-Q or CNS-B entered all prescriber orders into resident's EMARs. RN-Q further stated it was "weird" R1's meclizine dosage was missing, the frequency was incorrect, and the reason to give the medication was missing. RN-Q stated R1's EMAR should have been fixed to reflect R1's current meclizine order. The licensee's Medication and Treatment Orders Implementation policy dated August 26, 2020, indicated upon receipt of a medication order changes will be made to the MAR, by a nurse, if indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed	01790			

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01790	Continued From page 91 nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility,	01790			

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01790	Continued From page 92 including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of one ULP (ULP)-D was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. UNPLANNED TIME AWAY POLICY AND PROCEDURE FOR ULP The licensee's Medication Administration-Outings policy dated August 26, 2020, indicated for unplanned resident time away the RN may delegate this task to the ULP for unplanned time	01790			

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01790	Continued From page 93 away not to exceed five days (120 hours). The policy indicated any medications not taken will be documented in the client's (resident's) record by the nurse that received the form and medications. The licensee's policy lacked written procedures the RN developed to include the following: -the RN has trained the ULP and determined the ULP is competent to follow the procedures for giving medications to residents; -the RN has developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the resident; -written information about the medications to be provided; -the type of container to be used for the medications appropriate to the facility's medication system; and -how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. TRAINING AND COMPETENCY EVALUATIONS ULP-D was hired on May 14, 2025, to provide direct care services to residents of the dementia care facility. On July 14, 2025, at 1:00 p.m., the surveyor observed ULP-D assisting residents in the secured unit. ULP-D's employee record lacked evidence to indicate ULP-D had been trained and had demonstrated competency to provide medications to residents for unplanned time away from the facility.	01790			

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01790	Continued From page 94 On July 18, 2025, at 11:55 a.m., RN-Q stated clinical nurse supervisor (CNS)-B trained the ULPs on sending medications with residents for unplanned times away. Furthermore, RN-Q stated when RN-Q was on-call, the ULPs would call RN-Q, and RN-Q instructed the ULPs to print out a medication page, put the medications in the little pill envelopes, and write the resident's name and time to take the medication on the envelope. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two 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).	01820			

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01820	Continued From page 95 The findings include: During the entrance conference on July 14, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD- difficult breathing). R1's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R1's services included medication administration. R1's Individual Abuse Prevention Plan dated July 11, 2025, indicated facility will manage all medications, staff to administer all medications, and ensure R1 takes ordered medications. R1's Med (medication) Admin (administration)- Actual- Month dated July 2025, indicated R1 received quetiapine (for agitation) 25 milligrams (mg) take one tablet by mouth twice per day. R1's prescriber orders signed on May 9, 2025, included an order for quetiapine 25 mg take one tablet by mouth twice daily. R1's prescriber orders signed July 11, 2025, after R1 returned from a hospitalization, included an order for quetiapine 25 mg by mouth every night at bedtime. The order had a handwritten note, which indicated Fax to 25 mg BID (twice per day) [sic], however, R1's record lacked documentation of a fax to clarify R1's quetiapine to be given once or twice daily.	01820			

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01820	Continued From page 96 R1's record lacked a prescriber order to resume administration of quetiapine 25 mg by mouth twice daily. On July 18, 2025, at 11:20 a.m., registered nurse (RN)-Q stated CNS-B must have missed sending a clarification order to R1's physician after R1's hospitalization to resume quetiapine 25 mg twice daily. The licensee's Medication and Treatment Orders policy dated August 26, 2020, indicated the RN is responsible for assuring that current, authorized prescriber orders for medication or treatments administered by the staff are kept on file in the client's (resident's) medical chart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with information regarding the direction for use, medication name, medication dosage,	01890			

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01890	Continued From page 97 resident's name, and the pharmacy in which it had been issued. In addition, the licensee failed to ensure medications were maintained to include opened date and expiration date for time sensitive medications stored and managed by the licensee for three of three medication carts (Memory, Main, Tower carts). 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: During the entrance conference on July 14, 2025, at 12:00 p.m., consultant (C)-C and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On June 23, 2025, from 12:45 p.m. through 1:45 p.m., the surveyor and C-C observed the following medications in the memory, main and tower medication carts: Memory cart -R10's morphine concentrate 20 milligram (mg) /milliliter (ml) (treats pain) 13 pre-drawn syringes lacked prescription label, date medication was drawn up and when it would expire; and -R11's opened Brio Ellipta (improves lung function) inhaler lacked prescription label, open and expiration dates.	01890			

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01890	Continued From page 98 Main cart -R6's opened Latanoprost 0.005 % (treats eye pressure) eyedrops lacked open and expiration dates. Tower cart -R2's opened Lantus 100 units/milliliter (ml) (treats high blood sugar) pens lacked open and expiration dates. The manufacturer instructions for Brio Ellipta dated November 2024, indicated to discard six weeks after you open the tray or when the counter reads "0", whichever comes first. The manufacturer instructions for latanoprost ophthalmic eye drops dated March 2022, indicated once bottle is opened, the bottle can be kept at room temperature for four weeks. The manufacturer instructions for Lantus dated June 2022, indicated to discard the pen after 28 days after it has been opened, even if it still has insulin left in it. On June 18, 2025, at 11:53 a.m., registered nurse (RN)-Q stated expectations are all medications should have a pharmacy label and time sensitive medications should be labeled with open and expiration dates. Furthermore, RN-Q stated hospice draws up the morphine into the syringes and was unaware the syringes were not labeled individually. The licensee's Storage of Medications policy dated August 26, 2020, indicated 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	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER MINNESOTA GREENLEAF		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701			
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01890	Continued From page 99 with legible information including the expiration or beyond use date of a time dated drug. Medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures	01930			

Minnesota Department of Health

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01930	Continued From page 100 that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to residents at the facility. On July 15, 2025, at 6:30 a.m., the surveyor observed unlicensed personnel (ULP)-S complete a blood glucose check for R12. The treatment and therapy policies provided did not include policies to address the following: -providing the treatment or therapy; -documenting the treatment or therapy; -monitoring and evaluating the treatment or therapy; and -communicating with the prescriber. On July 16, 2025 at 10:15 a.m., consultant (C)-C stated C-C provided all the documentation to the surveyor C-C had access too. On July 17, 2025, at 8:14 p.m., C-C emailed (electronic mail) C-C had provided all policies the surveyor requested, however, no additional treatment or therapy policies were provided to the	01930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/18/2025
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01930	Continued From page 101 surveyor. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01930			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, 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	02040			

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02040	Continued From page 102 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). Findings include: A record review and interview were conducted on July 15, 2025, at 10:45 a.m. with assistant director (AD) -E on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and	02170			

Minnesota Department of Health

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02170	Continued From page 103 non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan for one of one resident (R1) who resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/18/2025
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02170	Continued From page 104 dementia care (ALFDC) license issued on November 1, 2024, through October 31, 2025. During the entrance conference on July 14, 2025, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. During the entrance tour on July 14, 2025, from 12:45 p.m. through 1:45 p.m., the surveyor observed white boards (erasable calendars) in the unsecured and secured units. The whiteboards in the unsecured unit indicated bingo on July 5, 6, and 14. Other past days from July were marked with an X, and July 15 through July 31 were blank. The surveyor observed no other activities written on the whiteboards. In the secured unit, the whiteboards read the same as the unsecured unit. The surveyor observed in the unsecured unit the residents sleeping in chairs, one resident working on a puzzle and a couple residents were visiting. In the secured unit, residents wandered in the hallways, were in their rooms, or were sitting at the tables with no activities. R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD- difficult breathing). R1 resided in secured unit. R1's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R1's services included medication administration, activity assistance, bathing, grooming, behavior management, dressing, safety checks, and housekeeping. R1's Individualized Activity Plan dated April 3, 2024, included an evaluation of the activity areas	02170			

Minnesota Department of Health

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02170	Continued From page 105 which were required, however, R1's record did not include an individualized activity plan with structured and non-structured activities specific for R1. On July 14, 2025, from 2:35 p.m. through 3:00 p.m., the surveyor interviewed R4. R4 stated the facility did not have an activity director and there was no activity calendar for the month of July. R4 stated she leads exercise on Mondays, Wednesdays and Fridays, and R5 leads exercises on Tuesdays and Thursdays. Furthermore, R4 stated the exercises are done in the secured unit or the residents in the secured unit would not participate in exercise. R5 stated R9 or another resident will call bingo when the residents want to play bingo. On July 15, 2025, from 9:00 a.m. through 9:30 a.m., the surveyor interviewed R5. R5 stated R5 was unsure if the facility had an activity director. Furthermore, R5 stated the facility did not have a formal activity program; the activities and exercises were led by residents. On July 18, 2025, at 11:25 a.m., registered nurse (RN)-Q stated the RN's completed an evaluation on a residents with a dementia diagnosis to include activities residents enjoy and activities residents are not interested in. RN-Q further stated the RNs only complete the evaluation and then "maybe" the administration would complete the individual activity plan with structured and non-structured activities for each resident since RN-Q was not required to be onsite at the facility. RN-Q stated RN-Q was aware a group activity was offered Monday through Friday at 10:00 a.m. at the facility, however, R1 did not always participate	02170			

Minnesota Department of Health

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02170	Continued From page 106 The licensee's Enrichment Programs/Activities policy dated April 2023, indicated an individualized activity plan will be developed for each resident based on their activity evaluation. The plan will reflect the residents' activity preferences and needs. In addition, a selection of daily structured and non-structured activities will be provided and included on the resident's activity service or care plan as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170			
02330 SS=D	144G.91 Subd. 5 Refusal of care or services Residents have the right to refuse care or assisted living services and to be informed by the facility of the medical, health-related, or psychological consequences of refusing care or services. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document any efforts to educate a resident who was repeatedly refusing daily weights ordered by a prescriber 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) 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).	02330			

Minnesota Department of Health

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02330	Continued From page 107 The findings include: R2's diagnoses included congestive heart failure and hypertension (high blood pressure). R2's unsigned Service Plan (Private)- FFS Addendum to Contract dated July 17, 2025, (four days after survey initiation) indicated R2's services included medication administration, activity assistance, meal attendance, escorts, oxygen management, safety checks, laundry and housekeeping. R2's prescriber orders dated June 24, 2025, indicated: -record daily weights, as ordered by prescriber; and -furosemide 20 milligrams(mg), take 2 (40 mg) tablets daily if weight increase greater than two pounds. R2's June 1, 2025, through July 15, 2025, electronic medication administration record (EMAR) indicated resident refused, declined, or scale (to take weights) was not working for daily weights the following days: -June 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 19, 22, 23, 24, 25, 26, 28, 29, 30; and -July 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15. R2's record lacked documentation R2 was informed by the facility of the medical and health related consequences of refusing care or services. On July 18, 2025, at 11:54 a.m., registered nurse (RN)-Q stated she was unaware R2 was refusing daily weights. RN-Q stated the staff should have contacted a nurse to follow-up and educate R2 of	02330			

Minnesota Department of Health

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02330	Continued From page 108 the consequences of refusing the daily weights. Furthermore, RN-Q was unsure when R2 refused daily weights, how many times staff would re-approach the resident to complete the task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02330			



Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Minnesota Greenleaf
1006 Greenwood Street E
Thief River Falls, MN 56701
Pennington County
Parcel:

Phone:

License Info

License: HFID 30342

Risk:
License:
Expires on:
CFPM: KELLY L CORNEILLIE
CFPM #: 38691; Exp: 9/22/2026

Inspection Info

Report Number: F1040251026
Inspection Type: Full - Single
Date: 7/15/2025 Time: 7:12:33 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-103.11B Priority Level: Priority 2 CFP#: 1

MN Rule 4626.0035B The person in charge must ensure only authorized persons are permitted in food preparation, food storage, and warewashing areas of the establishment.

COMMENT: AT TIME OF INSPECTION WAS INFORMED THAT RESIDENTS WERE FOUND IN THE KITCHEN ACCESSING REFRIGERATORS

Comply By: 7/15/2025 Originally Issued On: 7/15/2025

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

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: OBSERVED RAW PASTEURIZED EGGS STORED ABOVE READY TO EAT COLESLAW

Comply By: 7/15/2025 Originally Issued On: 7/15/2025

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 Priority Level: Priority 1 CFP#: 22

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

COMMENT: OBSERVED MILK IN MEMORY CARE UNIT AT 48F IN MINI FRIDGE, OBSERVED DISPOSAL OF MILK AND INSTRUCTED TO NOT KEEP MILK AND OTHER TCS ITEMS IN MINI FRIDGE. MILK GALLONS AND JUICE PITCHER ARE KEPT OUT DURING MEAL SERVICE IN ICE FOR OVER AN HOUR WHILE ON ICE, INSTRUCTED TO TOSS AFTER EACH SERVICE IF USING ICE TO KEEP COLD.

Comply By: Complied On Site Originally Issued On: 7/15/2025

New Order: 4-200 Equipment Design and Construction

4-201.11AMN Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: OBSERVED DOMESTIC FRIDGE BEING USED TO STORE MILK IN MAIN KITCHEN, AND MILK IN MEMORY CARE UNIT. ALSO OBSERVED ROASTER/SLOW COOKER BEING USED TO HOT HOLD ITEMS UNTIL SERVICE IN MAIN KITCHEN (UNSERVED ITEMS ARE TOSSED AFTER EACH SERVICE)

Comply By: 8/15/2025 Originally Issued On: 7/15/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: AT TIME OF INSPECTION NO THIN TIP THERMOMETER AVAILABLE

Comply By: 7/22/2025 Originally Issued On: 7/15/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

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

COMMENT: AT TIME OF INSPECTION NO LACTIC ACID TEST STRIPS AVAILABLE

Comply By: 7/18/2025 Originally Issued On: 7/15/2025

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 Bemidji District Office inspection report number F1040251026 from 7/15/2025



DIANA
FOOD SERVICE

Vania Jeh,
Public Health Sanitarian 1
218-308-2124
vania.jeh@state.mn.us



Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Page: 1

Establishment Info

Minnesota Greenleaf
Thief River Falls
County/Group: Pennington County

Inspection Info

Report Number: F1040251026
Inspection Type: Full
Date: 7/15/2025
Time: 7:12:33 AM

Food Temperature: Product/Item/Unit: MEMORY CARE MINI FRIDGE, MILK; Temperature Process: Cold-Holding

Location: COOLER at 48F Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: Product/Item/Unit: COOKED FRIED CHICKEN; Temperature Process: Cooking

Location: Oven at 180 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: 2-DOOR COOLER, JELLO; Temperature Process: Cold-Holding

Location: Upright Cooler at 41F Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: DOMESTIC FRIDGE, CHOCOLATE MILK; Temperature Process: Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: MEMORY CARE MINI FRIDGE, PACKAGED YOGURT; Temperature Process: Cold-Holding

Location: Cooler at 41F Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: FREEZER 1; Temperature Process: Cold-Holding

Location: Upright Freezer at 0 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: FREEZER 2; Temperature Process: Cold-Holding

Location: Upright Freezer at 0 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Freezer at 0F Degrees F.

Comment:

Violation Issued?: No



Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Minnesota Greenleaf
Thief River Falls
County/Group: Pennington County

Inspection Info

Report Number: F1040251026
Inspection Type: Full
Date: 7/15/2025
Time: 7:12:33 AM

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

Location: Dishwashing Area **Greater Than** 160F Degrees F.

Comment: MEASURED WITH THERMOLABEL

Violation Issued?: No

Sanitizing Chemical: Product: Lactic Acid; **Sanitizing Process:** Dispenser

Location: 3-Comp Sink **Equal To** PPM

Comment:

Violation Issued?: No