Electronically Delivered

April 16, 2025

Licensee
First Light Residential Care LLC
801 East 84th Street
Bloomington, MN 55420

RE: Project Number(s) SL40566015

Dear Licensee:

On April 8, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 8, 2025 . This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

March 21, 2025

Licensee
First Light Residential Care LLC
801 East 84th Street
Bloomington, MN 55420

RE: Project Number(s) SL40566015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on January 8, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

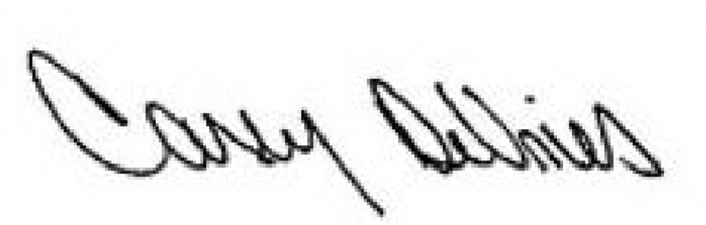
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: 651-201-5917
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40566	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST LIGHT RESIDENTIAL CARE LLC	801 EAST 84TH STREET BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40566015-0 On January 6, 2025, through January 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three resident(s); three receiving services under the Assisted Living Facility Provisional license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 470	Continued From page 1	0 470		
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 on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents,	0 470		

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0 470	Continued From page 2 staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 6, 2025, at 9:49 a.m., clinical nurse supervisor/licensed assisted living direct/owner (CNS/LALD/O)-D stated the licensee's shifts were 7:00 a.m., until 3:00 p.m., 3:00 p.m., until 11:00 p.m., and 11:00 p.m., until 7:00 a.m. CNS/LALD/O-D stated there was one unlicensed personnel (ULP) each shift. CNS/LALD/O-D stated house manager/owner (HM/O)-C worked from 10:00 a.m., until 6:00 p.m. CNS/LALD/O-D stated they typically worked Monday, Tuesday, and Friday, four hours each day, and was on call 24 hours per day, seven days per week. On January 6, 2025, at 10:33 a.m., the surveyor observed a three-level assisted living facility. On the main level was a hallway connecting two common areas. In the hallway was a display notice box that contained a documented titled [licensee] Staffing Plan. The staffing plan lacked an evaluation performed by a registered nurse and a signature from a RN. On January 6, 2025, at 1:14 p.m., CNS/LALD/O-D stated they were aware the staffing plan was required to be dated and signed. CNS/LALD/O-D stated they forgot to sign	0 470		

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0 470	Continued From page 3 and date the staffing plan. The licensee's Staffing policy dated August 1, 2021, indicated the staffing plan would be evaluated at least twice a year. 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: (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	0 480		

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0 480	Continued From page 4 operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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0 480	Continued From page 5 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) January 7, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of 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 interview and record review, the licensee failed to ensure the assisted living	0 485		

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0 485	Continued From page 6 contract did not require any resident to include and pay for meals as a part of their assisted living package fee for three of three residents (R1, R2, R3) 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: R1 R1 was admitted to the facility May 31, 2024, and began receiving assisted living services. R1's [licensee] Assisted Living Contract signed May 30, 2024, page 3, included the following statement, "[licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [licensee]." R2 R2 was admitted to the licensee May 24, 2024, and began receiving assisted living services. R2's [licensee] Assisted Living Contract signed May 24, 2024, page 2, included the following statement, "[licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [licensee]."	0 485		

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0 485	Continued From page 7 R3 R3 was admitted to the licensee May 23, 2024, and began receiving assisted living services. R3's [licensee] Assisted Living Contract signed May 24, 2024, page 5, included the following statement, "[licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [licensee]." On January 6, 2025, at 2:01 p.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D provided a blank [licensee] Assisted Living Contract. Page 3 included the following statement, "[licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [licensee]." CNS/LALD/O-D stated the same contract was used for all residents. On January 7, 2025, at 12:27 p.m., CNS/LALD/O-D stated the contract was provided by a consultant company, and they were unaware that food fees should not be included in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following	0 500		

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0 500	Continued From page 8 and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel	0 500		

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0 500	Continued From page 9 performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. 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: On January 6, 2025, at 8:12 a.m., the surveyor emailed the licensee that an onsite assisted living facility survey would be initiated on January 6, 2025, at approximately 9:30 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee failed to provide the following policies and procedures during or after the survey process: -background studies. On January 8, 2025, at 8:51 a.m., clinical nurse supervisor/licensed assisted living direct/owner (CNS/LALD/O)-D stated they were aware each employee required a cleared background study completed prior to providing direct care services. CNS/LALD/O-D stated they were unaware of the required policies for the assisted living facility.	0 500		

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0 500	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice had the potential to affect the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 11 The findings include: SHARED MEDICAL EQUIPMENT On January 7, 2025, at 8:28 a.m., the surveyor observed unlicensed personnel (ULP)-B remove a blood pressure cuff, an oxygen saturation device (a device that measures oxygen levels in the resident), an infrared thermometer (measures body temperature without coming into contact with residents), and a blood glucose device (measures the sugar levels) from a cabinet located on the main level of the facility. ULP-B walked into R2's room and stated they were going to use the vital sign equipment. ULP-B placed the oxygen saturation device onto R2's right middle finger and recorded the reading then removed the device. ULP-B placed the blood pressure cuff onto R2's right arm, pressed the button and recorded the reading then removed the blood pressure cuff. ULP-B used the thermometer close to R2's forehead and recorded the reading. ULP-B placed the blood glucose device near a sensor (a circular device that is attached to a resident that measures blood glucose) located on R2's right arm and recorded the reading. ULP-B left R2's room, walked back to the cabinet, and without wiping down the vital sign equipment, placed the vital sign equipment back into the cabinet. On January 7, 2025, at 9:29 a.m., ULP-B stated the vital sign equipment was used for all residents and they were trained to wipe it down after each use. ULP-B stated they forgot to wipe down the vital sign equipment. On January 7, 2025, at 9:43 a.m., clinical nurse supervisor/licensed assisted living director/owner	0 510		

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0 510	Continued From page 12 (CNS/LALD/O)-D stated staff were trained to wipe down the vital sign equipment after each use with a Lysol wipe. The CDC's Disinfection of Healthcare Equipment guidance, dated November 23, 2023, indicated it was a requirement to clean equipment with appropriate disinfectant after contact with a blood or other potentially infectious materials. In addition, medical equipment surfaces should be disinfected with an environmental protection agency (EPA) registered low or intermediate level disinfectant. CLEAN ENVIRONMENT On January 6, 2025, at 10:33 a.m., the surveyor observed an attached garage to the three-level assisted living facility. In the garage was a refrigerator that contained 11 insulin aspart injection pens (a device that is used to inject medications) and six insulin Basaglar injection pens. On the top shelf inside the refrigerator were three dead houseflies. On January 8, 2025, at 8:36 a.m., ULP-B stated they were responsible for cleaning the assisted living facility including cleaning the refrigerator that contained the insulin pens. On January 8, 2025, at 8:40 a.m., CNS/LALD/O-D stated staff were trained to clean the refrigerator weekly using Clorox disinfectant wipes. CNS/LALD/O-D stated there was no cleaning log completed by staff. CNS/LALD/O-D stated there should not be flies in the refrigerator and staff may not have noticed them. The licensee's Infection Control policy dated August 1, 2021, indicated the license would follow	0 510		

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0 510	Continued From page 13 recommendations made by the Center for Disease Control (CDC). The CDC Environmental Services guidance dated January 8, 2024, recommended insects should be kept out of all areas of health-care facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 630		

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0 630	Continued From page 14 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee May 24, 2024, and began receiving assisted living services. R2's diagnoses included diabetes insulin dependent diabetes mellitus (IDDM type one), hip replacement (surgically replaced hip joint), schizo-affective disorder (chronic mental illness that combines symptoms of schizophrenia (mental disorder that may result in hallucinators that may include hearing and seeing things that are not observed by others, delusions, and disorganized thinking) and a mood disorder such as bipolar disorder (mental illness that causes extreme shifts in mood, energy activity levels and concentration). R2's IAPP dated September 11, 2024, indicated R2 was at risk to abuse by others, however lacked statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On January 7, 2025, at 12:42 p.m., clinical nurse supervisor/licensed assisted living direct/owner (CNS/LALD/O)-D stated they were aware the IAPP had to include interventions and stated they were missed when completing the IAPP for R2. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated licensee would complete a IAPP for each resident to include their	0 630		

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0 630	Continued From page 15 risk to abuse another individual and their risk to be abused by another individual, and to include suitable interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 680		

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0 680	Continued From page 16 by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated July 2021, lacked evidence of the following required content: - annual review and updates of the EP plan including risk assessment; - policies and procedures for volunteers; - roles under a waiver declared by secretary;-methods for sharing information; - names and contact information for entities providing services under agreement, residents physicians, other facilities, and volunteers; - sharing information on occupancy and needs; - long-term care (LTC) family notifications, and - emergency preparation and testing requirements. On January 8, 2025, at 8:43 a.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D stated a consultant company was used to create the EP plan for the facility. CNS/LALD/O-D stated they were unaware of the	0 680		

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0 680	Continued From page 17 required content for the EP plan and the EP plan was a work in progress. The licensee's Emergency Preparedness policy dated August 1, 2025, indicated licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate, and safe smoking practices. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 6, 2025, from 11:00 a.m. to 12:45 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D. Survey staff asked CNS/LALD/O-D to initiate a test of the smoke alarms throughout the facility. Upon testing, it was found that the smoke alarm located in the common hallway directly outside of resident rooms 4, and 5 were not interconnected with the rest of the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all	0 780		

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0 780	Continued From page 19 alarms within the dwelling unit. There was evidence of unsafe smoking practices happening in resident room 5. There were burn marks on the nightstand, ash on the nightstand, three small plastic/light aluminum containers that were being used as ash trays, and a burn mark in the carpet on the right side of the bed. Smoking shall be done safely, and cigarettes discarded into approved non-combustible ash trays placed on a sturdy surface. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 20 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 6, 2025, from 11:00 a.m. to 12:45 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Portable fire extinguishers must be provided with monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	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	0 800		

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0 800	Continued From page 21 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 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: On January 6, 2025, from 11:00 a.m. to 12:45 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D. During the tour, the surveyor asked CNS/LALD/O-D to open the windows in the resident bedrooms for measurements. In resident room 4 CNS/LALD/O-D stated that they could not open the window because the handle used to operate the crank was missing. CNS/LALD/O-D asked the resident if they knew where the crank was. Resident located the crank	0 800		

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0 800	Continued From page 22 inside of a small table next to their recliner. CNS/LADL/O-D attempted to reinstall the crank and found it to be damaged and not able to be reinstalled. The windows shall be maintained in an operable condition at all times. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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.	0 810		

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0 810	Continued From page 23 (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on 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 January 6, 2025, clinical nurse supervisor/licensed assisted living director/owner (CNS/ LALD/O)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire policy", dated August 1, 2021, failed to include the following: The FSEP included standard employee	0 810		

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0 810	Continued From page 24 procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On January 6, 2025, at 12:45 p.m., CNS/LALD/O-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS/LALD/O-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.	0 810		

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0 810	Continued From page 25 The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. CNS/LALD/O-D stated that staff training is done on a third-party software using the third-party vendors FSEP and training material. The surveyor explained to CNS/LALD/O-D that training needs to be done on the facilities written FSEP. No other training documentation was provided. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Evacuation drill record", undated, indicated evacuation drills were conducted on May 27, 2024, June 3, 2024, June 8, 2024, June 13, 2024, June 23, 2024, June 29, 2024, July 7, 2024, July 16, 2024, July 21, 2024, July 27, 2024, August 3, 2024, August 12, 2024, August 16, 2024, August 22, 2024, August 30, 2024, and September 6, 2024. No other documentation was provided. On January 6, 2025, at 12:45 p.m., CNS/LALD/O-D stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing	0 830		

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	40566	A. BUILDING: _____ B. WING _____	01/08/2025

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0 830	Continued From page 26 regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was admitted to the facility May 31, 2024, and began receiving assisted living services. R1's diagnoses included anxiety disorder, attention-deficit-hypertension-disorder, chronic obstructive pulmonary disease (a disease that affects airflow into the lungs making breathing difficult), hypertension (high blood pressure), tobacco use, neurologic abnormality (a condition that affects nerves, brain or spinal cord that can cause a range of symptoms), recurrent major depressive disorder, post-traumatic stress disorder (PTSD) (mental and behavioral disorder that can develop after experiencing a traumatic event), homeless, agitation, gross hematuria (blood in urine), bladder tumor (cancer in the	0 830		

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0 830	Continued From page 27 bladder), and right inguinal hernia (a bulge in the groin). R1's Service Plan (Wavier) - Addendum to Contracted dated June 10, 2024, indicated R1 received the following services: activity assistance, ambulation, bedmaking, dressing, grooming, housing keeping, laundry, behavior management, medication management, vital signs, remove garbage, skin treatment, and toileting. On January 6, 2025, at 10:33 a.m., the surveyor observed a three-level assisted living facility. In R1's bedroom was a bed, a TV on a dresser, and a recliner chair with two cup holders either side. Behind the dresser was a small circular foil pan. In the pan was a white ash type substance. Directly next to the circular foil pan was white ash type substance. On the carpet directly below was a nickel sized black shape burn mark on the carpet. In both cupholders of the recliner, in the base of cupholder was a white ash substance in the circular shape. On the left side seat edge was a white ash type substance, more concentrated at the corner. R1's Progress Note dated June 1, 2024, through January 6, 2025, indicated R1 was observed smoking in their room on June 23, 2024. The progress note indicated R1 was reminded that no smoking was allowed in the assisted living facility. There were no other entries made related to R1 smoking in the facility. On January 6, 2025, at 11:05 a.m., unlicensed personnel (ULP)-B stated they observed R1 smoking while they sat in the recliner chair. ULP-B stated they told R1 not to smoke in their room and had informed house manager/owner	0 830		

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0 830	Continued From page 28 (HM/O)-C that R1 smoked in their room. ULP-B stated they could not remember what date they observed R1 smoking in their room. ULP-B stated R1 would keep smoking even when told not to smoke inside. On January 6, 2025, at 11:19 a.m., HM/O-C stated the licensee's policy was residents were not permitted to smoke inside the facility. HM/O-C stated R1 had many mental health issues and was argumentative with staff. On January 6, 2025, at 1:00 p.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D stated smoking was not permitted inside the assisted living facility, and they had posted signs informing residents and staff no smoking was allowed inside. CNS/LALD/O-D stated R1 had a history of physical and abusive behaviors. CNS/LALD/O-D stated they trained staff to document if R1 was observed smoking in their room, but they were unsure if staff were documenting smoking if it was observed. CNS/LALD/O-D stated they gave a verbal warning of eviction to R1 if the smoking continued but did not document the verbal warning. CNS/LALD/O-D stated the plan was to have R1 sign an acknowledgement that smoking was not permitted and if R1 continued to smoke, the licensee would start the eviction process. CNS/LALD/O-D stated they were going to email R1's case manager today (January 6, 2025) to schedule a meeting to discuss the situation. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed	0 830		

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0 830	Continued From page 29 by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. MCIAA defined smoking to include carrying or using an activated electronic delivery device. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 830		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced	0 970		

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0 970	Continued From page 30 by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 R1 was admitted to the facility May 31, 2024, and began receiving assisted living services. R1's [licensee] Assisted Living Contract signed May 30, 2024, page 11, included the following statement, "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents." R2 R2 was admitted to the licensee May 24, 2024, and began receiving assisted living services.	0 970		

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0 970	Continued From page 31 R2's [licensee] Assisted Living Contract signed May 24, 2024, page 10, included the following statement, "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents." R3 R3 was admitted to the licensee May 23, 2024, and began receiving assisted living services. R3's [licensee] Assisted Living Contract signed May 24, 2024, page 13, included the following statement, "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents." On January 6, 2025, at 2:01 p.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D provided a blank Assisted Living Contract. Page 13 included the following statement, "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence	0 970		

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0 970	Continued From page 32 of [licensee] or its employees or agents." CNS/LALD/O-D stated the same contract was used for all residents. On January 7, 2025, at 12:27 p.m. clinical nurse supervisor/licensed assisted living director/owner stated they recently learned the liability clause could not be included in the contract and it was an oversight for including that statement in the resident contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility 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;	01730		

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01730	Continued From page 33 (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	01730		

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01730	Continued From page 34 The findings include: R1 R1 was admitted to the facility May 31, 2024, and began receiving assisted living services. R1's diagnoses included anxiety disorder, attention-deficit-hypertension-disorder, chronic obstructive pulmonary disease (a disease that affects airflow into the lungs making breathing difficult), hypertension (high blood pressure), tobacco use, neurologic abnormality (a condition that affects nerves, brain or spinal cord that can cause a range of symptoms), recurrent major depressive disorder, post-traumatic stress disorder (PTSD) (mental and behavioral disorder that can develop after experiencing a traumatic event), homeless, agitation, gross hematuria (blood in urine), bladder tumor (cancer in the bladder), and right inguinal hernia (a bulge in the groin area). R1's Service Plan (Wavier) - Addendum to Contracted dated June 10, 2024, indicated R1 received the following services: medication management. R1's Medication Administration Record dated January 1, 2025, through January 7, 2025, indicated R1 received the following medications: amlodipine 5 mg 1 tablet once daily, aspirin 81 mg 1 tablet once daily, gabapentin 300 mg 1 capsule twice daily, losartan 100 1 tablet once daily, metoprolol succinate 50 mg 1 tablet once daily, nicotine 14 mg/24-hour patch apply one patch to skin once daily, risperidone one half tablet three times daily, tamsulosin 0.4 1 capsule once daily, atorvastatin 40 mg 1 tablet once daily, Trelegy Ellipta 100-62.5-25 mcg inhaler 1 puff once daily, acetaminophen extra strength 500 mg	01730		

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01730	Continued From page 35 1 tablet every six hours, albuterol inhaler 108 (90 base) microgram (mcg) 1-2 puffs every four hours, Nicotine Polacrilex gum 2 mg every one hour as needed, oxybutynin 5 mg 1 tablet twice daily, sildenafil 100 tablet take one half tablet to 1 full tablet as needed and trazodone 1 tablet at bedtime. R1's record, comprised of multiple documents, lacked the following information: - procedures for staff notifying a registered nurse (RN) when a problem arises with a medication management service. R2 R2 was admitted to the licensee May 24, 2024, and began receiving assisted living services. R2's diagnoses included diabetes insulin dependent diabetes mellitus (IDDM type one), hip replacement (surgically replaced hip joint), schizo-affective disorder (chronic mental illness that combines symptoms of schizophrenia (mental disorder that may result in hallucinators that may include hearing and seeing things that are not observed by others, delusions, and disorganized thinking) and a mood disorder such as bipolar disorder (mental illness that causes extreme shifts in mood, energy activity levels and concentration). R2's Service Plan (Wavier) - Addendum to Contracted dated May 24, 2024, indicated R2 received the following services: medication management. R2's Medication Administration Record dated January 1, 2025, through January 7, 2025, indicated R2 received the following medications: aripiprazole 10 mg 1 tablet once daily, aspirin 81	01730		

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01730	Continued From page 36 mg 1 tablet once daily, Basaglar Kwikpen (injection pen) 100 units (u) subcutaneously (under the skin) twice daily, furosemide 40 mg tablet 1 once daily, isosorbide mononitrate 20 mg 4 and one-half tablets once daily, Jardiance 25 mg 1 tablet once daily, losartan 25 1 tablet once daily, metformin 1000 mg 1 tablet once daily, Novolog Flexpen (injection pen) dosed on based a blood glucose reading, propranolol 20 mg 1 tablet once daily, sertraline 50 mg 1 tablet once daily, Topamax 50 mg 1 tablet once daily, ferrous sulfate 325 mg 1tablet once daily, hydrochlorothiazide 25 mg 1 tablet once daily, multivitamin tablet 1 tablet once daily, vitamin B-1 100mg 1 tablet once daily, vitamin C 500 mg 1 tablet once daily, vitamin D3 1000 u 2 capsules once daily, atorvastatin 80 mg 1 tablet once daily, lamotrigine 25 mg 2 tablets once daily, acetaminophen 500 mg 2 tablets every six hours, cyclobenzaprine 5 mg 1 tablet at bedtime as needed, glucose 4 mg chew 1 tablet for low blood sugar, ibuprofen 200 mg 2 tablets every six hours as needed. On January 7, 2025, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-B administer insulin to R2. R2's record, comprised of multiple documents, lacked the following information: - procedures for staff notifying a registered nurse (RN) when a problem arises with a medication management service. R3 R3 was admitted to the licensee May 23, 2024, and began receiving assisted living services. R3's diagnoses included of schizophrenia (mental disorder that may result in hallucinators that may	01730		

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01730	Continued From page 37 include hearing and seeing things that are not observed by others, delusions, and disorganized thinking), history of alcohol abuse, osteoarthritis of both knees (chronic disease that causes the breakdown of cartilage and bone in the joints), arthritis of the left hip, thalassemia (a chronic condition that prevents the body form producing enough hemoglobin (the cells in the body that carry the oxygen), hypertension (high blood pressure), human immunodeficiency virus (HIV), and tobacco abuse. R3's Service Plan (Wavier) - Addendum to Contracted dated May 28, 2024, indicated R3 received the following services: medication management. R3's Medication Administration Record dated January 1, 2025, through January 7, 2025, indicated R3 received the following medications: amlodipine 10 mg 1 tablet once daily, escitalopram oxalate 20 mg 1 tablet once daily, fluticasone 50 mcg 1 spray in each nostril (nose) once daily, hydroxyzine 25 mg 1 tablet two times daily, triamcinolone acetonide 0.1 % apply to skin lesions once daily, aripiprazole 7 mg 1 tablet once daily, atorvastatin 80 mg 1 tablet once daily, dolutegravir sodium 50 mg 1 tablet once daily, emtricitabine and tenofovir 200-25 mg 1 tablet once daily, gabapentin 300 mg 2 capsules two times day, urea 20 intensive hydrating 20 % apply to hands and feet, acetaminophen 500 mg 1 tablet by mouth as needed ammonium lactate 12 % cream apply topically two times a day, Aquaphor cream apply to hands and feet, artificial tears 0.2-0.2-1 1 drop in each eye, and diclofenac 1 % gel apply to left hip as needed. R3's record, comprised of multiple documents, lacked the following information:	01730		

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01730	Continued From page 38 - procedures for staff notifying a registered nurse (RN) when a problem arises with a medication management service. On January 7, 2025, at 12:46 p.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D stated they were responsible for the medication management plans for the residents. CNS/LALD/O-D stated they completed the medication management plan with 90-day assessments for each resident. CNS/LALD/O-D stated it was hard to remember the required details for the medication management plan. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated licensee would develop and maintain a medication management plan to include plans for staff to notify the RN when a problem occurs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=E	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 written or electronically recorded prescriptions were obtained for two of three residents (R1, R3).	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40566	A. BUILDING: _____ B. WING _____	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST LIGHT RESIDENTIAL CARE LLC	801 EAST 84TH STREET BLOOMINGTON, MN 55420

(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
01820	Continued From page 39 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the facility May 31, 2024, and began receiving assisted living services. R1's diagnoses included anxiety disorder, attention-deficit-hypertension-disorder, chronic obstructive pulmonary disease (a disease that affects airflow into the lungs making breathing difficult), hypertension (high blood pressure), tobacco use, neurologic abnormality (a condition that affects nerves, brain or spinal cord that can cause a range of symptoms), recurrent major depressive disorder, post-traumatic stress disorder (PTSD) (mental and behavioral disorder that can develop after experiencing a traumatic event), homeless, agitation, gross hematuria (blood in urine), bladder tumor (cancer in the bladder), and right inguinal hernia (a bulge in the groin area). R1's Service Plan (Wavier) - Addendum to Contracted dated June 10, 2024, indicated R1 received the following services: medication management. R1's Medication Administration Record dated	01820		

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	40566	A. BUILDING: _____ B. WING _____	01/08/2025

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01820	Continued From page 40 January 1, 2025, through January 7, 2025, indicated R1 received the following medications: amlodipine 5 mg 1 tablet once daily, aspirin 81 mg 1 tablet once daily, gabapentin 300 mg 1 capsule twice daily, losartan 100 1 tablet once daily, metoprolol succinate 50 mg 1 tablet once daily, nicotine 14 mg/24-hour patch apply one patch to skin once daily, risperidone one half tablet three times daily, tamsulosin 0.4 1 capsule once daily, atorvastatin 40 mg 1 tablet once daily, Trelegy Ellipta 100-62.5-25 mcg inhaler 1 puff once daily, acetaminophen extra strength 500 mg 1 tablet every six hours, albuterol inhaler 108 (90 base) microgram (mcg) 1-2 puffs every four hours, Nicotine Polacrilex gum 2 mg every one hour as needed, oxybutynin 5 mg 1 tablet twice daily, sildenafil 100 tablet take one half tablet to 1 full tablet as needed and trazodone 1 tablet at bedtime. R1's record contained a document Medication and Treatment Orders signed by an authorized prescriber dated May 1, 2024. The documented indicated R1 was to receive metoprolol 50 milligram (mg). There was another document attached to the Medication and Treatment Orders titled After Visit Summary for R1 dated April 26, 2024. The document indicated R1 received the following medications: acetaminophen extra strength 500 mg 1 tablet every six hours, albuterol 108 (90 base) microgram (mcg) 1-2 puffs every four hours, amlodipine 5 mg 1 tablet once daily, antacid regular strength 200-200-20 mg/5 milliliter (ml) take 30 ml three times as needed, aspirin 81 mg 1 tablet once daily, atorvastatin 40 mg once daily, clonazepam 1 mg 1 tablet by mouth as needed, docusate sodium-sennosides 50-8.6 1 tablet twice daily, gabapentin 300 mg 1 capsule twice daily, ibuprofen 200 mg 1 tablet three times daily,	01820		

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FIRST LIGHT RESIDENTIAL CARE LLC	801 EAST 84TH STREET BLOOMINGTON, MN 55420

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01820	Continued From page 41 losartan 100 mg 1 tablet once daily, metoprolol succinate 50 mg 1 tablet once daily, muscle rub 10-15 percent (%) cream apply to shoulder for pain, nicotine 14 mg/24-hour patch apply one patch to skin once daily, oxybutynin 5 mg 1 tablet twice daily, polyethylene glycol 3350 17 gram (gm) 1 capful 17 mg once daily, risperidone one half tablet three times daily, sildenafil 100 tablet take one half tablet to 1 full tablet as needed, tamsulosin 0.4 1 capsule once daily, Trelegy Ellipta 100-62.5-25 mcg inhaler 1 puff once daily and, vyvanse 70 mg 1 tablet by mouth once daily. For each of the medications listed on the AVS there was a prescriber name only. The document titled After Visit Summary for R1 lacked a manual or electronic prescriber signature. The following medications were listed on the AVS but were not listed on R1's MAR: antacid regular strength 200-200-20 mg/5 milliliter (ml) take 30 ml three times as needed, clonazepam 1 mg 1 tablet by mouth as needed, docusate sodium-sennosides 50-8.6 1 tablet twice daily, muscle rub 10-15 percent (%) cream apply to shoulder for pain and, vyvanse 70 mg 1 tablet by mouth once daily. The following medications were listed on the MAR but were not listed on the AVS: Nicotine Polacrilex gum 2 mg every one hour as needed and trazodone (no dose listed) 1 tablet at bedtime. R3 R3 was admitted to the licensee May 23, 2024, and began receiving assisted living services. R3's diagnoses included of schizophrenia (mental disorder that may result in hallucinators that may	01820		

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01820	Continued From page 42 include hearing and seeing things that are not observed by others, delusions, and disorganized thinking), history of alcohol abuse, osteoarthritis of both knees (chronic disease that causes the breakdown of cartilage and bone in the joints), arthritis of the left hip, thalassemia (a chronic condition that prevents the body form producing enough hemoglobin (the cells in the body that carry the oxygen), hypertension (high blood pressure), human immunodeficiency virus (HIV), and tobacco abuse. R3's Service Plan (Wavier) - Addendum to Contracted dated May 28, 2024, indicated R3 received the following services: medication management. R3's Medication Administration Record dated January 1, 2025, through January 7, 2025, indicated R3 received the following medications: amlodipine 10 mg 1 tablet once daily, escitalopram oxalate 20 mg 1 tablet once daily, fluticasone 50 mcg 1 spray in each nostril (nose) once daily, hydroxyzine 25 mg 1 tablet two times daily, triamcinolone acetonide 0.1 % apply to skin lesions once daily, aripiprazole 7 mg 1 tablet once daily, atorvastatin 80 mg 1 tablet once daily, dolutegravir sodium 50 mg 1 tablet once daily, emtricitabine and tenofovir 200-25 mg 1 tablet once daily, gabapentin 300 mg 2 capsules two times day, urea 20 intensive hydrating 20 % apply to hands and feet, acetaminophen 500 mg 1 tablet by mouth as needed ammonium lactate 12 % cream apply topically two times a day, Aquaphor cream apply to hands and feet, artificial tears 0.2-0.2-1 1 drop in each eye, and diclofenac 1 % gel apply to left hip as needed. R3's record contained a document titled After Visit Summary dated April 25, 2024. The	01820		

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01820	Continued From page 43 document indicated R3 received the following medications: amlodipine 10 mg 1 tablet once daily, ammonium lactate 12 % cream apply topically two times a day, aripiprazole 7 mg 1 tablet once daily, atorvastatin 80 mg 1 tablet once daily, carboxymethylcellulose one half % eye drop 1 drop in each eye every four hours, diclofenac 1 % apply topically four times daily, escitalopram oxalate 20 mg 1 tablet once daily, gabapentin 300 mg 2 capsules two times day, hydrochlorothiazide 25 mg 1 tablet once daily, hydroxyzine 25 mg 1 tablet two times daily, olmesartan 20 mg 1 tablet once daily, urea 20 intensive hydrating 20 % apply to hands and feet. R3's record contained an additional document titled After Visit Summary dated September 9, 2024. The document indicated R3 received the following medications: acetaminophen 500 mg 1 tablet by mouth as needed, amlodipine 10 mg 1 tablet once daily, ammonium lactate 12 % cream apply topically two times a day, Aquaphor cream apply to hands and feet, aripiprazole 5 mg 1 tablet once daily, artificial tears 0.2-0.2-1 1 drop in each eye, atorvastatin 80 mg 1 tablet once daily, deep sea nasal spray 0.65 % inhale 2 sprays into each nose twice daily, emtricitabine and tenofovir 200-25 mg 1 tablet once daily, diclofenac 1 % gel apply to left hip as needed, dolutegravir sodium 50 mg 1 tablet once daily, escitalopram oxalate 20 mg 1 tablet once daily, fluticasone 50 mcg 1 spray in each nostril (nose) once daily, gabapentin 300 mg 2 capsules two times day,, hydroxyzine 25 mg 1 tablet two times daily, lidocaine 5 % patch apply to most painful area for maximum of 12 hours, nicotine oral 10 mg inhaler inhale 1 cartridge every hour as needed, triamcinolone acetonide 0.1 % apply to skin lesions once daily, and, urea 20 intensive hydrating 20 % apply to hands and feet.	01820		

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01820	Continued From page 44 The following medications were listed on the two AVS' but were not listed on R3's MAR: hydroxyzine 25 mg 1 tablet two times daily, and olmesartan 20 mg 1 tablet once daily. The following medications were listed on the MAR but were not listed on the two AVS': fluticasone 1 spray in each nostril (nose) once daily, triamcinolone acetonide 0.1 % apply to skin lesions once daily, dolutegravir sodium 1 tablet once daily, emtricitabine and tenofovir 200-25 mg 1 tablet once daily, urea 20 intensive hydrating 20 % apply to hands and feet and, acetaminophen 1 tablet by mouth as needed. For each of the medications listed on the AVS there was a prescriber name only. The document's titled After Visit Summary for R3 dated April 25, 2024, and September 9, 2024, lacked a manual or electronic prescriber signature. On September 7, 2025, at 1:31 p.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D stated they believed having the prescriber's name next to the medication on the AVS was the prescriber signature. CNS/LALD/O-D stated the MAR and prescriber orders should match. The licensee's Medication Orders dated August 1, 2021, indicated the registered nurse (RN) would administer medications as prescribed by the authorized prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of three residents (R2) who received insulin. Additionally, the licensed failed to ensure to permit only authorized personnel to have access to medications for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: MANUFACTURER'S INSTRUCTIONS On January 6, 2025, at 10:33 a.m., the surveyor observed an attached garage to the assisted living facility. In the garage was a refrigerator that contained 11 insulin aspart injection pens (a device that is used to inject medications) and six insulin Basaglar injection pens. There was no temperature log, and the refrigerator lacked a	01880		

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01880	Continued From page 46 thermometer. On January 7, 2025, at 9:41 a.m., unlicensed personnel (ULP)-B stated they were not trained to check the temperature of the refrigerator in the garage. The surveyor observed ULP-B open the refrigerator. ULP-B was not able to show the surveyor a thermometer. On January 7, 2024, at 9:49 a.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D stated the insulin injection pens should be stored according to manufacturer's instructions. CNS/LALD/O-D stated there was a thermometer in the refrigerator. The surveyor observed CNS/LALD/O-D open the refrigerator and state, "I was hoping the thermometer was there." CNS/LALD/O-D stated that situation should not have occurred and was an oversight. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated licensee would store medications according to manufacturer's directions. The manufacturer's guidelines for the use of Insulin aspart insulin pen dated November 2022, indicated unused pens should be stored in the refrigerator at 36 degrees to 46 degrees Fahrenheit. The manufacturer's guidelines for the use of Basaglar injection pen dated October 2024 indicated unused pens should be stored in the refrigerator at 36 degrees to 46 degrees Fahrenheit. SECURED MEDICATIONS On January 6, 2025, at 10:33 a.m., the surveyor	01880		

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01880	Continued From page 47 observed a cabinet in a resident common area that contained resident medications. On January 7, 2025, at 9:26 a.m., the surveyor observed a set of keys with a plastic spring cord on top of the medication cabinet. There were no staff present in the combined kitchen, dining, and common area. On January 7, 2025, at 9:41 a.m., ULP-B stated they were trained to secure the keys by always keeping them on their person. ULP-B stated they forgot to take the keys with them. On January 7, 2025, at 9:59 a.m., CNS/LALD/O-D stated staff were trained to always keep the keys on their person, and the keys should not have been left on top of the cabinet and was human error. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated the licensee would only allow authorized staff to have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this	03090		

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03090	Continued From page 48 subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to 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: On January 6, 2025, at 9:40 a.m., the surveyor observed signage on the front door of the assisted living facility, "Notice security cameras and audio recording in use." On January 6, 2025, at 1:19 p.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-D stated they were of the required language and the current signage was incorrect. CNS/LALD/O-D stated they purchased a new sign but had not posted it in the facility. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated licensee would post signage stating, "electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."	03090		

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03090	Continued From page 49 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *01/07/25*
Time: 11:40:38
Report: 1018251006

Food and Beverage Establishment Inspection Report

Location:
First Light Residential
801 EAST 84TH STREET
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0043999
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

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

3-302.11A(1) ***** Priority 1 *****

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

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE FRIDGE. COMPLY WITH RULE.

Comply By: 01/07/25

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

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.

ESTABLISHMENT DOES NOT CURRENTLY HAVE A THERMOMETER FOR CHECKING FOOD TEMPERATURES. COMPLY WITH RULE.

Comply By: 01/07/25

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding / BUTTER
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Type: Full
Date: *01/07/25*
Time: 11:40:38
Report: 1018251006
First Light Residential

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	0

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

ESTABLISHMENT IS DOING ALL SAME DAY SERVICE OF FOODS.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

KITCHEN HAS A TWO BASIN SINK WITH ONE SINK SPECIFICALLY FOR HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE. TEST STRIP INDICATED APPROPRIATE TEMPERATURE WAS ACHIEVED DURING CYCLE.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018251006 of 01/07/25.

Certified Food Protection Manager SHAMSO M HASSAN

Certification Number: FM111609 Expires: 08/20/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
SHAMSO HASSAN

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us